NORTHERN NEVADA LABORERS' HEALTH AND WELFARE TRUST FUND

Summary Plan Description for Active and Retired Employees and Their Eligible Dependents

KEEP THIS BOOKLET FOR FUTURE REFERENCE

Laborers' International Union of North America | LiUNA! Local 169 Feel the Power

AMENDED, RESTATED AND EFFECTIVE February 1, 2025

Asistencia en Español

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Ingles. Si usted tiene dificultad en entender este documento, por favor pongase en contacto con la Trust Fund Office a la dirección y teléfono en el Quick Reference Chart de este documento.

NORTHERN NEVADA LABORERS'
HEALTH AND WELFARE TRUST FUND

445 Apple Street, Suite 109
Reno, Nevada 89502
Phone: (775) 826-7200 Fax: (775) 826-5080

P. O. Box 11337
Reno, Nevada 89510-1337
Toll Free (877) 826-5053

EMPLOYER TRUSTEES
Craig Madole, Co-Chairman
Dave Backman
Craig Holt
Jarrett Rosenau-Alternate

UNION TRUSTEES
Eloy Jara, Chairman
Mike Kinney
Richard "Skip" Daly

LEGAL COUNSEL
Neyhart, Anderson, Flynn & Grosboll APC
369 Pine St., Suite 800
San Francisco, CA 94104-3323

CONSULTANTS
Benefit Plan Administrators, Inc.
445 Apple Street, Suite 109
Reno, Nevada 89502

ACCOUNTANT
Casey Neilon
6770 S. McCarran
Blvd., Ste 200
Reno, NV 89521

TRUST FUND OFFICE
Benefit Plan Administrators, Inc.
P.O. Box 11337
Reno, Nevada 89510-1337

FUND MANAGER
Benefit Plan Administrators, Inc.
P.O. Box 11337
Reno, Nevada 89510-1337

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TO ALL ELIGIBLE EMPLOYEES:

We are pleased to provide you with this booklet describing your health care and insurance benefits under the Northern Nevada Laborers Health and Welfare Trust Fund as of February 1, 2025.

This booklet covers the benefits for which the Fund pays the claims for you and your eligible dependents. The benefits included are medical, mental health/substance use disorder, prescription drug, dental, vision care, and weekly disability benefits.

This booklet also covers benefits for which the Fund contracts with insurance companies - life insurance for you and your dependents as well as accidental death and dismemberment insurance.

Summary Plan Description

This booklet is your Summary Plan Description (SPD) - a summary of the formal documents that govern the operation of the Plan. The SPD is not intended to provide full details or interpret Plan provisions or to extend or change in any way the provisions of the Plan. If there are any conflicts between the simplified descriptions in the SPD and the Plan Rules and Regulations or the Trust Agreement, the Rules and Regulations and, particularly, the Trust Agreement will take precedence.

About Your Benefits

The nature and amount of Plan benefits are always subject to the terms of the Plan as it exists at the time a claim occurs. These are not guaranteed lifetime benefits.

You can make the most of your benefits and keep costs down for everyone by taking advantage of the Board's Preferred Provider Organization (PPO) arrangements with a number of health care providers and facilities. These arrangements are designed to lower costs without reducing the level of care available to you. PPO Providers offer services at negotiated rates to Plan participants. Refer to the PPO Provider directory or contact the Trust Fund Office for more information.

Questions?

We encourage you to read this booklet carefully and keep it handy for future reference. You should share this booklet with those members of your family who are or will be covered by the Plan.

If you have questions about your benefits, contact the Trust Fund Office at the address or telephone number above. You should understand, however, that only the full Board of Trustees is authorized to interpret the benefits described in this booklet and that this authority cannot be delegated to Trust Fund Office staff. In addition, no employer or union, or any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees or act as an agent of the Board of Trustees.

Sincerely,

BOARD OF TRUSTEES

Contents

Chapter 1

Overview

What This Document Tells You

This Summary Plan Description describes the medical, mental health & substance use disorder, dental, vision, short-term disability, life insurance, and accidental death and dismemberment insurance benefits of the Northern Nevada Laborers Health and Welfare Trust Fund hereafter referred to as "the Fund." The Plan described in this document is effective, February 1, 2025, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

In this chapter you'll find: Information about this document, an overview of your benefits and contact information

- To determine if you are in a class of individuals who are eligible for benefits under this Plan, refer to the Eligibility section of Chapter 2 in this document. Coverage for eligible dependents will be conditioned on you providing proof of dependent status satisfactory to the Plan. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. **No individual shall have accrued or vested rights to benefits under this Plan.** A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. **Plan benefits are not vested and are not guaranteed**.

This document will help you understand and use the benefits provided by the Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Glossary.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information. A Quick Reference Chart to sources of help or information about the Plan appears in this chapter.

IMPORTANT INFORMATION

The Northern Nevada Health and Welfare Trust Fund is committed to maintaining health care coverage for employees and their families at an affordable cost; however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan was established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical, prescription drug, dental and vision benefits of the Plan are self-funded with contributions from Employers and Eligible Employees and Retirees held in a Trust. An independent Claims Administrator pays benefits out of Trust assets. The life and accidental death and dismemberment benefits of the Plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

CAUTION – FUTURE PLAN AMENDMENTS

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. The Board of Trustees may change eligibility requirements and any other Plan rules at any time. You will be notified in writing if there are important amendments to the Plan.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights.

You are <u>not</u> entitled to rely upon oral statements from Employees of the Fund Office, a Trustee, an Employer, any Union officer or any other person. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits or otherwise.

If you wish an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **To make their decision, the Trustees must be furnished with full and accurate information concerning your situation**.

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon an audit or review. **<u>The Board of Trustees reserves the right to make corrections whenever any error and/or overpayment is discovered</u>**.

For a list of Preferred Providers please contact the Trust Fund Office for a separate directory list/booklet or go to the plan's website 169laborers.com for a copy of the PPO Directory as well as quarterly updates. IMPORTANT: Using a Non-Contract Provider or Facility would result in a greater out-of-pocket expense for you. Please contact the Trust Fund Office for current information and refer to the preferred provider's directory booklet. Please note that your Network is in a constant state of change, if you go out of network then your out-of-pocket cost will be higher. Before services are rendered, please verify the physician's Preferred Provider status by calling the Trust Fund Office or checking the website 169laborers.com.

<u>QUICK REMINDERS OF YOUR RESPONSIBILITIES.</u>

- **It is your responsibility to notify the Plan Administrator of all changes to your address so that you continue to receive notices of important Plan changes that may affect you and/or your family's coverage. To request an Enrollment/Change form please contact the Trust Fund office.**

- **It is your responsibility to notify the Plan Administrator as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty unless it is impossible or unreasonable to give such notice.**

- **It is your responsibility to notify the Plan Administrator of any changes in your family situation, such as divorce or dissolution and child aging out of the Plan.**

- **It is your responsibility to provide an accurate Beneficiary Designation form at the time of initial enrollment. If you decide to change your beneficiary, you will need to complete a new form.**

- **There are privacy rules to protect you based on federal legislation known as HIPAA. If you wish to authorize someone to access information from the Trust Fund office on your behalf, please complete an Authorization for Release of Protected Health Information and return it to the Trust Fund office.**

- **If your claim involves a third-party with liability (ex. automobile accident) it is your responsibility to notify the Plan Administrator and complete and return an Accident Questionnaire and Agreement to Reimburse the Plan before the Plan will advance any benefits related to your third-party liability injury.**

- **If an Employer has not made fringe benefit contributions on your behalf , please notify the Plan Administrator immediately as this could potentially impact your coverage under the Plan.**

Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (The Affordable Care Act)

This Board of Trustees of the Northern Nevada Laborers Health and Welfare Trust Fund 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 non-grandfathered 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 dollar 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 Trust Fund Office at (775) 826- 7200 or Toll Free at (877) 826-5053. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Implementation of the ACA's provision began with the September 1, 2011, Plan Year.

Plan benefits are summarized in the chart below.

OVERVIEW OF BENEFITS FOR ELIGIBLE EMPLOYEES		
Benefit	**Who Can Be Covered**	**Description**
Comprehensive Major Medical, Mental Health, Behavioral Health or Substance Use Disorder Benefits	You and your eligible dependents	This Plan has a PPO provider feature that allows you to keep your share of the costs down.
Prescription Drug	You and your eligible dependents	Covers the cost of prescription drugs under your Comprehensive Major Medical plan, after deductible, pay 100% and at the pharmacy and then send RX receipt in for reimbursement to receive 80% back after deductible has been met.
Dental	You and your eligible dependents	Up to $2,500 per Calendar year for preventive, basic, and major dental services per person (calendar year limit not applicable to dependents up to age 19). PPO Provider 75/25 coinsurance, no deductible.
Orthodontia	You and your eligible dependents	$1,000 lifetime benefit, payable at 50% coinsurance.
Vision	You and your eligible dependents	Provides you with reimbursements toward the cost of an Eye Exam. Choice of glasses or contacts once per calendar year. A PPO Provider feature allows you to keep your share of the costs down.
Weekly Disability	You (Employee Only)	Helps replace lost income when you (the Employee) are disabled, paying $250 per week for up to 13 weeks. Benefits begin the first day for a disability caused by accidental injury or on the 8th day for a disability caused by illness.
Employee Life Insurance	You (Employee Only)	$10,000.00 Brick Hod Carriers, Plaster Hod Carriers, Laborers. $25,000.00 Plasterers, Cement Masons, Flat Raters. $1,000.00 Retirees
Dependent Life Insurance	Your eligible dependents	$2,000.00 Spouse and Dependent Children (of active employees only)
Accidental Death and Dismemberment Insurance	You (Employee Only)	$10,000.00 Brick Hod Carriers, Plaster Hod Carriers, Laborers. $25,000.00 Plasterers, Cement Masons, Flat Raters

More detailed information, including charts showing covered service or losses, can be found in the chapters describing the individual benefits. Also see Chapter 15: Other Important Plan Information for general provisions regarding your benefits.

Who to Contact for Assistance

The following chart provides a handy reference guide to telephone numbers you'll see in this SPD:

Quick Reference Chart	
Information Needed	**Whom to Contact**
Trust Fund Office • Medical and Dental Claims • Eligibility for Coverage • Benefit Information • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • Claim Appeals for medical, dental, vision, short-term disability claims. **COBRA Administrator** • Information About COBRA • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification **PPO Providers- In network Facilities, and Provider list.** • PPO Provider Directory • Website: 169laborers.com • Additions/Deletions of PPO Providers **Weekly Disability Coverage** • Weekly Disability Claims and Appeals **Utilization Review (UR) Program** • Precertification of Admissions and Medical Services • Second and Third Opinions • Case Management • Appeals of UM decisions	**Northern Nevada Laborers Health and Welfare Trust Fund** 445 Apple Street Suite 109 Reno, NV 89502 P.O. Box 11337 Reno, NV 89510 Phone: (775) 826-7200 Toll Free: (877) 826-5053 General Fax: (775) 824-5080 **CAUTION:** Use of a Non-PPO hospital, facility or provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Fund's payment for a covered service. **Your lowest out of pocket costs will occur when you use PPO Providers**.
Prescription Drug Benefits administered by the Prescription Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information	**OptumRx** (855) 672-3644 or www.optumrx.com TDD assistance: (855) 672-3644 (TTY 711) Mail order: • For physicians to call in prescriptions: (800) 797-7658. • For participants: (855) 672-3644 • Specialty pharmacy services, call (855) 672-3644 or (866) 218-5445
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Northern Nevada Laborers Health and Welfare Trust Fund** Jim Mace 445 Apple Street P.O. Box 11337 Reno, NV 89510 Phone: (775) 826-7200 Toll Free: (877) 826-5053
Life Insurance, Accidental Death and Dismemberment Benefits • Claims and appeals for life insurance, accidental death and dismemberment benefits	**The Union Labor Life Insurance Company** 8403 Colesville Road, 13th Floor Renee – Life Claims Mail Stop #709 Silver Spring, MD 20910

Chapter 2

Participating in the Benefit Plan

In This Chapter You'll Find:

Who Is Eligible for Coverage and Start of Coverage

To establish and maintain eligibility, you must meet the work hour requirement for collectively bargained employees or the contribution requirements for non-bargained employees. The requirements are described later in this chapter.

Employee Eligibility

You are eligible to participate in this Plan if you are an Employee of a Contributing Employer and work under a Collective Bargaining Agreement requiring contributions to the Northern Nevada Laborers Health and Welfare Trust Fund which has been approved by the Board of Trustees.

Collectively Bargained Employees

Your Hour Bank

The hours you work for contributing employers accumulate in an hour bank. Hours are then deducted each month to pay for your benefits. Each month, 100 hours will be deducted, beginning with your first month of eligibility. To maintain your eligibility, you must work at least 100 hours per month for contributing employers (or have excess hours in your hour bank, as explained below).

Banking Excess Hours

Whenever you work more than 100 hours during a month (or have more than 100 hours credited to you under these eligibility rules), the excess hours will be accumulated to provide subsequent eligibility. Active employees covered by an applicable collective bargaining agreement with Laborers Local 169 can accumulate up to 600 excess hours in your hour bank. Active employees covered by an applicable collective bargaining agreement with Operative Plasterers and Cement Masons Local 797 can accumulate up to 600 excess hours in your hour bank.

NOTE: Excess hours cannot extend coverage for periods in which you are working in non-qualifying employment - including working for a non-contributing employer performing work covered by the Laborers Local 169 or Operative Plasterers & Cement Masons Local 797 collective bargaining agreements, working under another collective bargaining agreement that does not require a contribution to the Fund, or you knowingly permit a contributing employer to contribute to the Fund for less than all of the hours you have worked, you will not be entitled to the benefit of this excess-hours provision, and all remaining hours in your hour bank will immediately be canceled.

When Coverage Starts

Your Coverage will become effective on the first day of the calendar month following a period of not more than four consecutive calendar months during which you worked a total of at least 400 hours. On the first day of the month of your eligibility, 100 hours will be deducted from your hour bank. If you have eligible dependents, each dependent will be covered for benefits when your eligibility is effective or when the individual becomes an eligible dependent, whichever is later.

When Coverage Ends

Except as provided regarding service in the Uniformed Services, your eligibility for benefits will terminate on the earliest of the following dates:

- midnight the last day of the month that your hour bank is exhausted.
- the last day of the month prior to the month in which you become eligible for coverage as a retired employee (but see Retired Employee Eligibility on page 10)
- the date the Plan terminates.
- Non-qualifying employment (ex. working in non-covered work or working for non-signatory employer)

Re-Establishing Eligibility

If you lose your eligibility (your coverage terminates) because your hour bank is exhausted, you will again become eligible on the first day of the calendar month after your hour bank shows at least 100 hours (through December 31, 2014), if this occurs within the 6 months immediately following the termination of coverage. If you are not reinstated within the 6 calendar-month period, any hours in your hour bank will be canceled and you must rebuild again from zero hours and meet the initial eligibility requirements (i.e., satisfy the 400-hour qualifying period applicable to new employees).

For example: Let's say you were last eligible for benefits in July 2024 and you next work 100 hours in December 2024. You would be eligible for benefits in January 2025. However, if you were last eligible in July 2025 but did not work 100 hours again until January 2025, you would need to re-establish eligibility by working 400 hours in four consecutive months or less.

Cancellation of Active Employee Reserve Account

Cancellation of Reserve Account. An Active Employee contributed upon at an hourly rate shall have his Reserve Account immediately cancelled when any of the following circumstances occur:

(1) The Active Employee permits a Contributing Employer to contribute to the Fund on the basis of fewer hours than he actually worked for that Contributing Employer.

(2) The Active Employee performs work of the type covered by the Collective Bargaining Agreement for an employer who is not a Contributing Employer.

(3) The Active Employee performs work covered by a Collective Bargaining Agreement other than a Collective Bargaining Agreement with the Union or another affiliate of the Laborers International Union of North America.

During the cancellation, no Benefits shall be extended to the Active Employee or their Dependents, however. If the Active Employee is reemployed under a Collective Bargaining Agreement with the Union or another affiliate of the Laborers International Union of North America by a Contributing Employer in accordance with provisions stated in Reinstatement of Active Employee Eligibility, then any remaining balance in the Active Employee's Reserve Account may be reinstated upon a request to the Board of Trustees.

When You Work in More than One Area

Reciprocity

Reciprocity provides eligibility for employees who would otherwise be ineligible for benefits because their work hours are divided between different health and welfare funds. Reciprocity operates only if the Laborers Union Local 169/Operative Plasterers & Cement Masons Union Local 797 have a Reciprocity Agreement that has been adopted by each of the funds in whose jurisdiction you work.

If you have any questions on the operation of the Reciprocal Agreements, or require a complete listing of Reciprocal Agreements, please contact either the Trust Fund Office or the fund office of the other plan under whose jurisdiction you are working.

If You Change to a Flat Rate Job

If you accumulate an hour bank and then change to a job status where flat rate contributions are made to the Trust Fund for you, your hour bank eligibility will be terminated with the start of your flat rate eligibility. More information about Flat Rate eligibility is provided below.

Flat Raters May Become Hourly

Flat raters may become hourly eligibles without meeting the 400-hour eligibility requirements; however, the Fund will not credit any hours to their hour bank for the first 100 bank hours. From that point the maximum hours in an Active Employee's Reserve Account may not exceed 600 hours.

Monthly Flat Rate and Non-Collectively Bargained Employees

Monthly Rates

Each flat rate contribution provides a single month of eligibility. Flat rate contributions paid in one month provide coverage beginning on the first day of the following month. You will become eligible on the first day of the month after the first required contribution is made.

Non-Collectively Bargained Employees

A Contributing Employer may contribute on behalf of full-time non-collectively bargained employees. The contribution rate is either hourly or a monthly flat rate, which is determined by the Board of Trustees. The Contributing Employer must make a written election to enroll the full-time non-collectively bargained employees. The Employer also has to complete and return a Subscription Agreement approved by the Board of Trustees.

When Coverage Starts

For Monthly Flat-Rate Non-Collectively bargained employees, coverage begins on the first day of the calendar month that follows receipt of the required contribution for that month (not to exceed 90 days after employment commences). For Hourly Collective Bargained employees, the first day of the calendar month following the month in which 400 hours have been contributed.

Maintaining Eligibility

Your eligibility will continue through the month following the last month in which the required contribution is made on your behalf. The monthly flat rates for non-collectively bargained employees do not provide an hour bank accumulation.

Termination of Eligibility for Employees

Except as provided regarding service in the Uniformed Services, your eligibility for benefits will terminate on the earliest of the following dates:

- the last day of the month for which the required monthly contribution is made on your behalf.
- the last day of the month prior to the month you become eligible for coverage as a retired employee.
- the date the Plan terminates.

Re-Establishing Eligibility

If you lose eligibility because the required contribution was not made, you will be reinstated on the first day of the month for which the required contribution is made.

Medicare applies to both Collective and Non-Collective Bargaining Employees

If you are still an active employee when you reach age 65, you may enroll in Medicare. This Plan will continue to provide primary coverage for you and Medicare will be secondary. When active employee status is lost (including when your hour bank is exhausted), Medicare will become primary, and this Plan will become secondary.

Dependent Eligibility

Eligible dependents can be covered for health care benefits and dependent life insurance. Your eligible dependents are:

- Your lawful spouse
- The Employee's children younger than 26 years of age (whether married or unmarried) if they are:

✓ Natural children; or

✓ Legally adopted children (from the date of placement or custody); or

✓ Stepchildren or foster children;

- Legally adopted children younger than 26 years of age, from the date child is placed for adoption (placed for adoption means the assumption and retention by the employee/participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation); The trust fund will need a copy of court documents to add the dependent and to keep the dependent enrolled.
- Stepchildren or foster children younger than 26 years of age; to enroll foster children you need to submit court documents showing you are the legal foster parent.
- Children under the age of 26 who are required to be covered by the Eligible Employee by a Qualified Medical Child Support Order (QMCSO). For more information on QMCSOs, see below.

If you elect coverage for yourself, you are also eligible for medical, dental, vision, and dependent life insurance coverage for your eligible Dependents on the latter of the day you become eligible for your own medical coverage or the day you acquire an eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment card including the dependent's Social Security Number (SSN), copy of birth certificate and any needed court documents. if that medical coverage is in effect for you on that day and you provide the Plan's required proof of Dependent status and pay any required contribution for coverage of the dependent(s) (if applicable).

A Dependent may not be enrolled for coverage unless the employee is also enrolled. Specific documentation to substantiate Dependent status will be required by the Plan.

Qualified Medical Child Support Orders (QMCSO)/National Medical Support Notice

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and enrolls dependent children as directed by such an Order. A Medical Child Support Order is any judgment, decree, or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law that:

- provides child support or health benefits coverage to a dependent child or
- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the employee does not enroll the dependent child, then the non-employee parent or state agency may enroll the child.

This Plan will also provide benefits in accordance with a National Medical Support Notice ("NMSN"). In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. To be qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the employee and the name and mailing address of each dependent child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such dependent child,
- the period of coverage to which the Order applies, and
- the name of each plan to which the Order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act. With that said the child(ren) listed in the QMCSO or NMSN must meet the Plan requirements of an eligible Dependent Child(ren) under the Plan rules.

Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No eligible dependent child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

When a Qualified Medical Child Support Order Is Received

If a proposed or final order is received, the Trust Fund Office will notify the employee, and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order." Within a reasonable time, the employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order or appeal the decision. (For information on appeals procedures, contact the Trust Fund Office.) If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMCSO and any required payments must be received prior to enrollment. Any child(ren) enrolled pursuant to an order will be subject to all provisions applicable to dependent coverage under the Plan.

Extended Eligibility for Disabled Children

You may continue coverage for dependent children beyond age 26 if they are prevented from earning a living because of a mental or physical disability. For them to continue receiving coverage, they must have been eligible dependents and already suffering from this disability when they reached age 26 and they must remain disabled, unmarried, and wholly dependent on you for support after age 26. You will need to file evidence of the child's dependence and incapacity with the Board within 31 days after the child reaches age 26 and periodically thereafter upon request.

Termination of Eligibility for Dependents

A dependent's eligibility will terminate when your coverage terminates or, for Dependent Children, on the Child's 26th birthday (except for eligible Disabled Children beyond age 26), and for all other coverage on the last day of the month in which the individual ceases to be an eligible dependent.

If You Have Coverage Elsewhere

If you or your dependents have health coverage elsewhere, you should be aware that benefits described in this booklet will be coordinated with the other coverage. You cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. Please see the **Coordination of Benefits** chapter 11 for more information.

Retired Employee Eligibility for Laborers

A Retired Employee shall be eligible for Fund Benefits for Retired Employees on the first day of the month for which a pension is payable from the Northern Nevada Laborers Pension Trust Fund, provided that the following requirements have been met:

- If the Employee is receiving a Reciprocal Pension, the majority of the Employee's Combined Credits are Northern Nevada Credits; and
- The Employee was eligible as an Active Employee for at least 24 out of the 48 months immediately preceding the effective date of the Employee's pension, or eligible for a Service Pension; and
- The Employee is no longer eligible for benefits as an Active Employee; and
- The Employee makes continuous, timely monthly payments to the Fund, in the amount fixed from time to time by the Board of Trustees, before the 20th of the month prior to the month in which the Employee is to be eligible; and
- The Employee is a member in good standing of Laborers Local 169.

Retired Employee Eligibility for Cement Masons

A Retired Employee shall be eligible for Fund Benefits for Retired Employees on the first day of the month for which a lump sum annuity is payable from the Cement Masons Annuity Trust Fund for Northern Nevada, provided that the following requirements have been met:

- The Employee was eligible as an Active Employee for at least 24 out of the last 48 months immediately preceding the effective date of the Employee's pension; and
- The Employee is no longer eligible for benefits as an Active Employee; and
- The Employee makes continuous, timely monthly payments to the Fund, in the amount fixed from time to time by the Board of Trustees, before the 20th of the month prior to the month in which the Employee is to be eligible; and
- The Employee is a member in good standing of Cement Masons Local 797.

Retired Employee Eligibility for Plasterers

A Retired Employee shall be eligible for Fund Benefits for Retired Employees on the first day of the month for which a pension is payable from the Valley Mortar Trades Pension Plan of Northern California, provided that the following requirements have been met:

- The Employee was eligible as an Active Employee for at least 24 out of the last 48 months immediately preceding the effective date of the Employee's pension; and
- The Employee is no longer eligible for benefits as an Active Employee; and
- The Employee makes continuous, timely monthly payments to the Fund, in the amount fixed from time to time by the Board of Trustees, before the 20th of the month prior to the month in which the Employee is to be eligible; and
- The Employee is a member in good standing of Cement Masons Local 797.

Retired Employee Eligibility for Non-Collectively Bargained Employees (Flat Raters)

A Retired Non-Collectively Bargained Employee that is not eligible for, or receiving, a pension from the Northern Nevada Laborers Pension Trust Fund shall be eligible for Fund Benefits for Retired Employees on the first day of the month following such Retired Non-Collectively Bargained Employee's retirement, provided that the following requirements have been met:

- Whether such Retired Non-Collectively Bargained Employee has retired shall be determined by the Board of Trustees in its sole discretion, based upon such documentation as the Board of Trustees requests in its sole discretion including, without limitation, documentation that the Retired Non-Collectively Bargained Employee has reached the age of 63.
- The Retired Non-Collectively Bargained Employee was eligible as an Active Non-Collectively Bargained Employee under Active Employee Eligibility of this plan for at least 120 out of the 132 months immediately preceding the effective date of the Non-Collectively Bargained Employee's retirement; and
- The Employee is no longer eligible for benefits as an Active Non-Collectively Bargained Employee; and
- The Retired Non-Collectively Bargained Employee makes continuous, timely monthly payments to the Fund, at the rate determined by the Board of Trustees from time to time in its sole and absolute discretion (which rate may differ from and exceed the rate applicable to other retirees covered under this plan), before the 20th of the month prior to the month in which the Employee is to be eligible.

Retired Employee Eligibility for Building Trades Apartment Employees

A Retired Building Trades Apartment Employee shall be eligible for Fund Benefits for Retired Employees on the first day of the month for which a person is no longer working, provided that the following requirements have been met:

- Whether such Retired Building Trades Apartment Employee has retired shall be determined by the Board of Trustees in its sole discretion, based upon such documentation as the Board of Trustees requests in its sole discretion including, without limitation, documentation that the Retired Non-Collectively Bargained Employee has reached the age of 63.
- The Retired Building Trades Apartment Employee was eligible as an Active Non-Collectively Bargained Employee under Active Employee Eligibility of this plan for at least 120 out of the 132 months immediately preceding the effective date of the Retired Building Trades Apartment Employee's retirement; and
- The Employee is no longer eligible for benefits as an Active Building Trades Apartment Employee; and
- The Retired Building Trades Apartment Employee makes continuous, timely monthly payments to the Fund, at the rate determined by the Board of Trustees from time to time in its sole and absolute discretion (which rate may differ from and exceed the rate applicable to other retirees covered under this plan), before the 20th of the month prior to the month in which the Employee is to be eligible.

Retired Employee Eligibility for BPA Employees

A BPA Employee shall be eligible for Fund Benefits for Retired Employees on the first day of the month for which a person is no longer working, providing that the following requirements have been met:

- Whether such Retired BPA Employee has retired shall be determined by the Board of Trustees in its sole discretion, based upon such documentation as the Board of Trustees requests in its sole discretion including, without limitation, documentation that the Retired BPA Employee has reached the age of 60.
- The Retired BPA Employee was eligible as an Active Employee under Active Employee Eligibility section, Eligibility for Collectively Bargained Employees section, and/or General Provisions for Non-Collectively Bargained Employees section of this Plan and/or eligible for COBRA coverage under Continuation Coverage (COBRA) section of this Plan for at least 120 out of the 132 months immediately preceding the effective date of the Retired BPA Employee's retirement after exhausting the Employee's hour bank; and
- The Employee is no longer eligible for benefits as an Active BPA Employee; and
- The Retired BPA Employee makes continuous, timely monthly payments to the Fund, at the rate determined by the Board of Trustees from time to time in its sole and absolute discretion (which rate may differ from and exceed the rate applicable to other retirees covered under this plan), before the 20th of the month prior to the month in which the Employee is to be eligible.

Reservation of Rights

The Board of Trustees of the Northern Nevada Laborers Health and Welfare Trust Fund reserves the right, in its sole and absolute discretion, to amend, modify, revoke, or terminate retiree coverage under the plan, in whole or in part, at any time. Without limitation, the Board of Trustees of the Northern Nevada Laborers Health and Welfare Fund reserves the right to: (1) discontinue retiree coverage for some or all classes of retirees; (2) to change the amount of the payments to be made for retiree coverage for some or all classes of retirees; and (3) to change any other term or condition upon which retiree coverage is offered, suspended, or terminated.

Termination of Retired Employee Eligibility

Eligibility for a Retired Employee shall terminate on the earliest of the following dates:

- The first day of the calendar month immediately following any month during which the Retiree (other than a Retired Non-Collectively Bargained Employee or a Bargained Employee or a Retired Building Trades Apartment Employee) is not eligible for a pension from the Northern Nevada Laborers Pension Trust Fund, the Cement Masons Annuity Trust Fund for Northern Nevada, or the Valley Mortar Trades Pension Plan of Northern California.
- The first day of the calendar month on which a Retiree (including a Retired Non-Collectively Bargained Employee and a Retired Building Trades Apartment Employee, BPA Employees) does not make the required monthly self-payment There shall be no reinstatement of Retired Employee eligibility that is terminated for this reason.
- The first day of the calendar month immediately following the date that a Retired Employee (including a Retired Non-Collectively Bargained Employee and a Retired Building Trades Apartment Employee) performs work in the building trade industry for an employer who is not a Contributing Employer to a Union Fund. There shall be no reinstatement of Retired

Employee eligibility that is terminated for this reason.

- The first day of the calendar month immediately following the date on which a Retired Employee that has previously been eligible for retiree health and welfare coverage pursuant to Retired Employee Eligibility has failed to reinstate the Retired.

  Employee's membership in the Union upon ninety days written notice that such membership has been suspended or terminated. There shall be no reinstatement of Retired Employee eligibility that is terminated for this reason.

- The date the Plan terminates.

Suspension of Retired Employee Eligibility

A Retired Employee's eligibility will be suspended on the last day of the month preceding any month during which he or she is not entitled to a pension from one of the Pension Funds listed in Retired Employee Eligibility, due to his or her returning to active work status without receiving advance approval pursuant to the retirement plan rules.

- Should Retired Employee eligibility be suspended, the Employee who has returned to active work status must become eligible as an Active Employee by satisfying the requirements for Active Employee eligibility as stated in Active Employee Eligibility.
- Should the Employee return to retirement, the Employee is again eligible for coverage under the provisions of Retired Employee Eligibility, provided he or she makes the required self-payments.

Extension of Eligibility for Surviving Spouse

The surviving spouse of a Retired Employee who had been self-paying for coverage, shall be allowed to continue Comprehensive Medical, Dental and Vision Benefits in force prior to the Retired Employee's death, as long as the required self-payment is made in a timely manner to the Fund, provided that:

- The surviving spouse had been married to the Retired Employee for at least two years on the first day of the calendar month following the date of the Retired Employee's death; and
- The surviving spouse remains unmarried and is not covered under another hospital, medical, or prescription drug plan (other than Medicare); and
- The surviving spouse provides annual certification of continuing eligibility for extended surviving spouse benefits in a form approved by the Board of Trustees; and
- The surviving spouse makes timely monthly payments to the Fund. The amount of self-payment will be determined by the Board of Trustees and shall be based upon the surviving spouse's eligibility for Medicare.

Dependent of Retired Employee Eligibility

An Eligible Dependent of a Retired Employee can be covered for health care benefits. Your eligible dependents are:

- Your lawful spouse
- Natural children younger than 26 years of age; or
- Legally adopted children younger than 26 years of age; or
- Stepchildren or foster children younger than 26 years of age; or
- Children under the age of 26 who are required to be covered by the Eligible Retiree by a Qualified Medical Child Support Order (QMCSO). For more information on QMCSOs, see page 13.

Anyone who does not qualify as a Dependent Child or Spouse as those terms are defined by this Plan has no right to any coverage for Plan benefits or services under this Plan.

A Dependent of a Retired Employee shall become eligible on the later of the following dates:

- On the date the Retired Employee's eligibility becomes effective; or
- For Newly Acquired Spouse: on the date they are legally married.
- For Newly Acquired Dependent Children: from the date of birth or the date child is placed for adoption (placed for adoption means the assumption and retention by the employee/participant of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement for adoption terminates upon the termination of such legal obligation).

An Eligible Dependent of a Retired Employee who is in the Hospital confined on the date he or she would otherwise have become covered will not become eligible until final discharge from the Hospital.

If you elect coverage for yourself, you are also eligible for medical coverage for your eligible Dependents on the latter of the day you become eligible for your own medical coverage or the day you acquire an eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment card including the dependent's Social Security Number (SSN) and if that medical coverage is in effect for you on that day and you provide the Plan's required proof of Dependent status and pay any required contribution for coverage of the dependent(s) (if applicable).

A Dependent may not be enrolled for coverage unless the employee is also enrolled. Specific documentation to substantiate Dependent status will be required by the Plan.

Termination of Eligibility of Dependent of Retired Employee

The eligibility of a Dependent of a Retired Employee will terminate on the earliest of:

- The date the Retired Employee's eligibility terminates, except that in the event of the Retired Employee's death, the surviving spouse may continue the same coverage in force prior to the Retired Employee's death through self-payments as described in Extension of Eligibility for Surviving Spouse; or
- The date he or she no longer qualifies as a Dependent; or
- The date the Plan terminates.

Enrollment

You must complete an enrollment form to designate your dependents for dependent coverage and designate your beneficiary(ies) for your life insurance and accidental death and dismemberment insurance. Enrollment forms can be obtained from your Local Union Office or the Trust Fund Office or on the Trust Fund website, 169laborers.com.

It is important that the Trust Fund Office have a completed enrollment form for you – your dependent(s)'s claims cannot be processed unless you have submitted the enrollment form with the necessary documents attached.

When submitting your enrollment form, you must provide specific documentation to substantiate Dependent status. Such documentation may include (see the list below) a copy of an official birth certificate, marriage certificate, proof of the dependent's age, other insurance inquiry form, and other documents deemed necessary by the Plan.

Note that a copy of a Dependent's Social Security Number (SSN) is also required to become eligible for coverage under the Plan.

- **Marriage: Copy of** the certified marriage certificate (if the marriage certificate is in a foreign language, it must be translated into English) and copy of social security card.
- **Birth:** the official birth certificate from the state or country showing the subject is the biological child of employee for each child that you enroll (if the birth certificate is in a foreign language, it must be translated into English), and a copy of each dependents social security card.
- **Stepchild:** Copy of the certified birth certificate, social security card, a copy of the divorce decree and copy of marriage certificate.
- **Adoption or placement for adoption**: court order paper signed by the judge showing that employee has adopted or intends to adopt the child, copy of birth certificate, and copy of social security card.
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgment, decree, or court order from a court of competent jurisdiction, plus the child's birth certificate and copy of social security card. Updated court documents will be needed to maintain eligibility.
- **Legal Guardianship:** the court-appointed legal guardianship documents and certified birth certificate, social security card. Updated court documents will be needed to maintain eligibility.
- **Disabled Dependent Child:** Current written statement from the child's Physician indicating that the child's diagnoses are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as that term disabled is defined in this document) and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; dependent chiefly relies on you and/or your Spouse for support and maintenance. The plan may require that you show proof of initial and ongoing disability, and that the child meets the Plan's definition of Dependent Child including social security card, and proof that the child is claimed as a dependent for federal income tax purposes.
- **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document signed by a judge or a National Medical Support Notice.

  Claims for newly added dependents (e.g. Spouse, children) will not be considered for payment by this Plan until the Plan Administrator receives a completed enrollment card and verification/proof of dependent status.

DEPENDENT SOCIAL SECURITY NUMBERS REQUIRED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Duty to Notify the Trust Fund Office of Changes

It is important that you notify the Trust Fund Office within 31 days if:

- you change your home address,
- you wish to change your beneficiary, or
- there is any change in your family status, i.e., marriage, birth of a child, adoption, divorce, death, etc.

If the change in family status is due to marriage, you must provide a copy of the certified marriage certificate. If the change in family status is due to a divorce, you must provide a copy of the divorce decree. Sometimes, getting the official documents can take some time. If this happens, notify the Trust Fund Office right away. Then, send the official documents as soon as they are available. You should complete a new beneficiary designation following the dissolution of marriage, even if you intend to re- designate your former spouse.

IMPORTANT: You will be held liable for benefit payments based on incorrect information about family members, for example, if you fail to notify the Trust Fund Office that you have divorced, a child has ceased to be an eligible dependent, or an adoption has been rescinded. In addition, you may be liable for other costs incurred by the Trust Fund as a result of the incorrect information. These costs include, but are not limited to, attorneys' fees, administrative costs, and reasonable interest.

An employee must reimburse the Plan for any benefits that were paid by the Plan for a Dependent at a time when that Dependent did not satisfy the definition of a Dependent or was not otherwise eligible for benefits under this Plan.

Option to Decline Dental Plan and/or Vision Plan Coverage

In accordance with Health Reform regulations, you have the option to decline the Plan's dental and vision coverage. To decline coverage, complete the portion of the Plan's enrollment card related to declining dental plan and/or vision plan coverage. Enrollment cards are available from the Trust Fund Office. If you decline dental and/or vision coverage you may re-enroll for such coverage after 12 months have lapsed by contacting the Trust Fund Office. Changes to the enrollment in dental plan and/or vision plan coverage are permitted once every 12-month period.

If you choose to opt out of the dental and/or vision plan benefits, there is **no incentive, reward or financial gain** paid to you or your dependents.

If you do not elect to opt out of dental and/or vision plan coverage, then you (and any eligible dependents) will automatically be enrolled in dental and vision coverage when you enroll for medical plan coverage.

Special Enrollment

This Plan complies with the Federal law regarding Special Enrollment by virtue of the fact that all eligible Employees and their eligible Dependents are automatically enrolled in this Plan as soon as the eligibility requirements of the Plan are met. There is no option to decline coverage. You need to provide the Trust Fund Office with your Dependent's social security number as well as certain documentation to show proof of dependent status (such as a marriage certificate, birth certificate). For more information about what paperwork may be needed to prove dependent status, please contact the Trust Fund Office.

Extension of Eligibility

Extended Medical Benefits for Total Disability

If you or a dependent is totally disabled (as certified by a physician within 90 days of the date of termination and at least once every 90 days while benefits are extended, the Fund must receive proof that the Participant continues to be Totally Disabled) on the date eligibility terminates, the disabled individual will remain eligible for comprehensive major medical benefits for the disability only for up to 12 months.

This extended coverage will end when the earliest of the following occurs:

- the disability ends,
- the disabled individual becomes covered under another group program that provides medical expense benefits, including COBRA continuation coverage, or
- the 12 continuous months of coverage following termination of eligibility have expired.

This extension applies only to the disabled person and not to other family members. It covers charges only for that disability. It is available at the time of termination of eligibility but not after COBRA coverage has been exhausted.

Extended Life Insurance Coverage If You Become Disabled

Your employee life insurance will stay in effect beyond the end of your eligibility as an active employee if you become totally disabled and unable to work while you are insured under the Plan and before you have reached age 60. For purposes of this extended benefit, "totally disabled" means that you are unable, due to illness or injury, to work in any business, occupation, or employment. The disability has existed uninterruptedly for 9 months, and the employee has not converted their Life Insurance Benefit. See Chapter 8: Employee Life Insurance for more information.

IMPORTANT NOTICE

You or your Dependents must promptly furnish to the Trust Fund Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, birth and change in status of a Dependent Child, Medicare enrollment or disenrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan within 31 days after any of the above noted events.

Failure to give the Trust Fund Office a timely notice of the above noted events may:

a. cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,

b. cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,

c. cause claims to not be able to be considered for payment until eligibility issues have been resolved,

d. result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future medical, dental, and/or vision benefits.

When the Plan Can End Your Coverage for Cause

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Leave of Absence (Special Circumstances)

Family and/or Medical Leave (FMLA)

Some larger employers and their employees may be covered under the Family and Medical Leave Act (FMLA), 29 USC §2601 et seq. The Fund assists Contributing Employers in complying with the FMLA by extending benefits during a qualified leave of absence, up to twelve weeks (sometimes up to 26 weeks) in a year. During your qualified FMLA leave, you and your eligible dependents continue to be covered under this Plan provided you were eligible and covered when the leave began. Your employer determines whether your leave is qualified. In general, the employers covered by FMLA are those who employ 50 or more employees within 75 miles for each working day during each of twenty or more calendar weeks in the current or preceding calendar year. If you are taking FMLA leave that has been approved by your employer, your employer is responsible for reporting the hours (or months for non-collectively bargained employees) and making contributions to the Plan on your behalf, as if you are working, in order to maintain your eligibility. To find out more about Family or Medical Leave and the terms on which you may be entitled to it, contact your Employer.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you enter military service, your rights to continuation and reinstatement of benefits will be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended. You have the option to either freeze your eligibility status or continue your coverage for up to 24 months during your military service.

This section outlines important information regarding your rights to continuation of coverage and reinstatement of coverage under USERRA.

USERRA Continuation Coverage allows you to maintain your benefits temporarily when they would otherwise end due to your service in the uniformed services. This protection applies to employees leaving for and returning from any type of service in the U.S. Armed Forces, including the Reserves, the Public Health Service, or any other category designated by the President during times of war or national emergency.

Duty to Notify the Plan

The Plan will offer the employee USERRA continuation coverage only after the Plan Administrator has been notified by the employee in writing that they have been called to active duty in the uniformed services. The employee must notify the Plan Administrator (contact information is on the Quick Reference Chart in the front of this document) as soon as possible but no later than 60 days after the date on which the employee will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Once the Plan Administrator receives notice that the employee has been called to active duty, the Plan will offer the right to Freeze eligibility or the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected, (both cannot be elected by the same person). Contact the Trust Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA. Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately.

Freezing of Your Eligibility

Provided you are eligible immediately before the start of the leave and your military service terminates under honorable conditions, you may choose to have your eligibility status frozen during your military service. If you are under the hour bank system, this includes freezing the balance in your hour bank.

If upon completion of service you notify your employer that you intend to return to employment as specified in USERRA, your eligibility will be reinstated. Eligibility will pick up as it was the day before you entered into Uniformed Services, without exclusion or waiting period, except for disabilities that the Department of Veterans Affairs has determined to be service connected.

An employee who is reemployed with a contributing employer in accordance with USERRA is entitled to all rights and benefits under the Plan that would have been attained if employment with a contributing employer had been continuous.

Continuation of Coverage

Alternatively, you and your dependents who were eligible and enrolled for benefits as of the date of your entry into service may elect to continue coverage. Depending on the length of your service, this may require you to pay premiums:

- If your absence is due to a uniformed services leave of 31 days or less, coverage will be continued for yourself and your eligible and enrolled dependents at no cost to you. You will be credited with the hours necessary to keep coverage in effect as if you were working in covered employment with a contributing employer during the period of service.
- If your absence is due to a uniformed services leave of more than 31 days, you or your dependents may elect to continue coverage by paying premiums under the provisions of USERRA.

A premium for continuation coverage under USERRA will be in an amount established by the Trust Fund. The premium will be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

- 24 months measured from the date the employee stopped working,
- a period ending on the day after you fail to return to employment within the time allowed by USERRA.

If you do not elect to continue coverage, eligibility status for yourself and your dependents will be frozen as of the date you stopped working. Eligibility for coverage for any eligible dependents will terminate at the end of the month in which you entered service in the Uniformed Services.

After Discharge from the Armed Forces

When the employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the employee returns to work provided the employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days: or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days: or
- at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The employee must notify the Plan Administrator in writing within the time periods listed above. Upon reinstatement, the employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Service-Connected Illnesses and Injuries

No benefits are provided by the Plan for illnesses or injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during performance of duties in the Uniformed Services.

Questions regarding your entitlement to an approved leave of absence and to the continuation of medical and dental coverage should be referred to your employer.

Continuation of Coverage

Legislation known as COBRA gives you and/or your dependents the option of continuing coverage at your own expense under certain circumstances when coverage would otherwise end. See Chapter 12: COBRA Temporary Continuation of Health Care Coverage on page 68 for more information.

If You Have Other Insurance

It is your responsibility to notify the Trust Fund Office if you have other insurance.
The other insurance inquiry form (which members are required to complete, sign, and submit to the Trust Fund Office at least once each calendar year) asks you whether you have other insurance. By entering the requested information on the form, you take care of your notification responsibility. If you do not respond to this form, it will result in claims being denied. You can find this form on 169laborers.com or at the Trust Fund office.

Chapter 3:

Comprehensive Medical Benefits

In this chapter you'll find:

- A quick-reference guide to medical benefits
- How the Plan works
- Your share of expenses – deductible and coinsurance
- Required procedures for hospitalization and substance use disorder treatment.
- Covered services and supplies.
- Exclusions from coverage
- Information on filing claims

Your comprehensive major medical benefits provide coverage for diagnosis and treatment of non-occupational Illnesses and Injuries, as well as certain preventive care. Included are hospitalization, surgery, and visits to the doctor. You do not have to be hospitalized to receive benefits.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

There are time limits for filing medical plan claims. All medical plan claims must be submitted to the plan within one year from the date of service. No plan benefits will be paid for any claim submitted after this period. For more information see section entitled "when claims must be filed" on page 27.

TIME LIMIT FOR REQUESTING A REVIEW AFTER NOTICE OF DENIAL OF A CLAIM

There are time limits for requesting a review after you receive a notice of denial for a claim. For more information see section entitled "request for review of an adverse benefit determination" on page 70.

TIME LIMIT FOR FILING A LAWSUIT

There are time limits for commencing a lawsuit to obtain benefits after a final decision has been reached on a review. For more information see section entitled "limitation on when a lawsuit may be started" on page 70.

The chart beginning on the following page is intended to provide a convenient quick-reference guide to your medical benefits. More detailed information, including conditions for payment of different services, follows the chart.

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
Calendar Year Deductible	Skill Class 21 (Plasterers) & 23 (Cement Masons) **$250 per person** with 4th quarter carry over, NO FAMILY DEDUCTIBLE Skill Class 22 (Brick Hod), 24 (Plasterer Hod) & 25 (Laborer) **$250 per person** with 4th quarter carry over: NO FAMILY DEDUCTIBLE Skill Class 27 (Non-Collectively Bargained) **$350 per person** with 4th quarter carry over: NO FAMILY DEDUCTIBLE	
Lifetime Medical Maximum	**None**	
Coinsurance Limit	Skill Class 22 (Brick Hod), 24 (Plasterer Hod) & 25 (Laborer) **$2,000** per person PPO charges (NONPPO Unlimited) (after deductible) Skill Class 21 (Plasterers) & 23 (Cement Masons) & Skill Class 27 (Non-Collectively Bargained) **$2,000** per person PPO Charges (NONPPO Unlimited) (after deductible)	
Acupuncture **(**Limited to 15 visits per Calendar Year. Maximum does not apply to treatment of mental health or substance use disorders.)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Ambulance	**80% Contracted Rate REMSA Ground** ***Air Ambulance 80% of Contracted Rate**	**60% of Non-PPO Fee Schedule** ***Air Ambulance subject to No Surprise Billing Act**
Chiropractic (Limited to 15 visits per Calendar Year)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Bariatric Surgery	After Deductible, 80% of Contracted Rate – Limit one surgery per lifetime	After Deductible, 60% of Non-PPO Fee Schedule
Cataract Surgery	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Colonoscopy • **Screening Over Age 45:** No precertification needed for age 45 and older (1 every 5 years) • **Diagnostic:** Under age 45 requires precertification	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Dialysis	NOT COVERED- See Exclusions	
Durable Medical Equipment	After Deductible, 90% of	After Deductible, 60% of Non-PPO Fee Schedule

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
(DME) (requires a prescription)	Contracted Rate	
Emergency Room $100 deductible per visit	After Deductible, 80% of Contracted Rate	After Deductible, 80% of Non-PPO Fee Schedule (subject to No Surprises Act)
Glucose Monitors	80% Covered under the Prescription Drug Plan if purchased from a Network pharmacy.	60% Covered under the Prescription Drug Plan if purchased from a Network pharmacy.
Hearing Aids	50% up to a maximum of every 3 years, subject to deductible	50% up to a maximum of every 3 years, subject to deductible
Home Health Care	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Hospice	After Deductible, 90% of Contracted Rate	After Deductible, 90% of Non-PPO Fee Schedule
Routine Immunizations for adults over age 19	Reimbursed at 100% up to the following allowed amounts (all other routine immunizations are excluded)**:** • **Flu $33** • **Pneumonia $224** • **Shingles $172 per shot (2 per year)** • **RSV $320**	
Inpatient Hospital	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Lab Work	100% Contract-Renown, LabCorp & Quest- 80% deductible all others	After Deductible, 60% of Non-PPO Fee Schedule
Medical Office Visits (including a specialty office visit)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Mental Health (Inpatient and Outpatient care including residential treatment, intensive outpatient treatment and partial hospitalization)	After Deductible, 80% of Contracted Rate Outpatient, no deductible applied	After Deductible, 60% of Non-PPO Fee Schedule
MRI/MRA/CAT or PET Scan	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Orthotics (must be custom Molded by M.D. or D.O.)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Outpatient Surgery	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
Physical Therapy (30 visits max per cal. year)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Maternity (Employee and Spouse ONLY)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Radiology	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Routine Annual Exam Employee and Spouse	No Deductible applied, 100% of Contracted Rate	No Deductible applied, 100% of Non-PPO Fee Schedule
Routine Gyn Exam (PAP SMEAR)	100% of Contract, 1 per calendar year	100% of Scheduled allowance, no deductible applies
Routine Mammogram	100% of Contract, 1 per calendar year, over age 35	100% of Scheduled allowance, no deductible applies
Skilled Nursing Facility	After Deductible, 80% of Contracted Rate	After Deductible, 50% of Non-PPO Fee Schedule
Speech and Occupational Therapy, ABA therapy	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Substance Use Disorder - Outpatient (including Intensive Outpatient Treatment and Partial Hospitalization)	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Substance Use Disorder - Inpatient and Detox	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Telemedicine services for mental health/substance is covered with all mental health/substance use providers.	After Deductible, 80% of Contracted Rate *Renown Rural telehealth when initiated through Renown.* All other Telemedicine services will be denied.	After Deductible, 60% of Non-PPO Fee Schedule
Urgent Care	After Deductible, 80% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Well Child Care (to age 19) Includes Immunizations	No Deductible applied, 100% of Contracted Rate	No Deductible applied, 100% of Non-PPO Fee Schedule
Short Term Disability	$250 per week, 13 weeks maximum	

How the Plan Works

Plan Participants may obtain health care services from PPO or Non-PPO Providers. But the amount that you pay for such services may vary.

Because Providers are added to and deleted from networks during the year you should call the Trust Fund Office or check the website 169laborers.com for updates or ask the provider to verify their contracted network status before you visit that provider to assure you will be able to receive their discounted price for the services you need.

PPO Providers

Your medical benefits have been structured to encourage you to use a PPO Provider - a Physician, hospital, or other health care professional or facility that has contracted with the Fund to provide services at a negotiated rate. If you use a PPO Provider, you pay only your deductible and your coinsurance for Medically Necessary covered services, subject to the Plan's limitations and exclusions. **Your lowest out-of-pocket costs occur when you use an in-network provider.**

> **Show your ID card to the health care provider every time you use services,** so they know that you are enrolled under this Plan and where to send their bills.

Non-PPO Providers

Non-PPO Providers (also called Non-participating providers) have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan participant for the Scheduled Allowance (as defined in this document) for any Medically Necessary services or supplies, subject to the Plan's deductibles, out of network coinsurance (on non- discounted services), copayments limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made.

- **CAUTION: Non-PPO Providers may bill you for any balance that may be due in addition to the Scheduled Allowance payable by the Plan, also called balance billing.** Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service. **You can avoid balance billing by using PPO Providers.**

- It generally costs you more money out of your own pocket if you use Non-PPO Providers, for example: Let's say you are scheduled for outpatient surgery. The Contracted Rate for the surgical procedure is $800, and the Scheduled Allowance is $500. If you use a PPO Provider, you pay only 20% of $800, or $160, assuming you previously satisfied the deductible. If you use a Non-PPO Provider, you pay 40% of the $500, or $200, plus 100% of any amount that doctor charges in excess of the $500 Scheduled Allowance. If the Non-PPO Provider billed charge was $1,000, your share of the costs would be $200 plus the $500 excess, or $600, if you previously satisfied the deductible.

If you would like to receive a copy of the line-item Scheduled Allowances relevant to the services you have received from a Non-PPO Provider, please contact the Trust Fund Office to obtain a copy free of charge.

Contract Rates and Scheduled Allowances

The Fund contracts with Hospitals, Physicians, Allied Health Care Practitioners, and other health care providers. These providers have agreed to Contract Rates. The Plan bases its payment on the contract rates.

Other providers have not agreed to contract rates. The Plan bases its payment to Non-PPO Providers on Scheduled Allowances. The Scheduled Allowance means the dollar amounts the Plan has determined will allow for the eligible Medically Necessary services or supplies performed by Non-PPO providers. Scheduled Allowances are established by the Board of Trustees and are subject to change. The Plan's Scheduled Allowances list is not based on or intended to be reflective of fees. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

Your Share of Expenses Annual Deductible

The deductible is the out-of-pocket expense you must pay during any one calendar year before the Fund pays benefits. Every person must meet an individual deductible of $250 or $350 of Covered Expenses incurred in a calendar year. The plan has no family deductible. Flat Raters have the $350 deductible, and all other Participants have the $250 deductible. Non-Covered Expenses, including expenses in excess of the Scheduled Allowances for a Non-PPO Provider, may not be used to satisfy the deductible. Covered Expenses incurred and applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next following calendar year. The deductible does not apply towards the Coinsurance maximum or Out-of-Pocket Limit.

Emergency Room Deductible

The deductible is the out-of-pocket expense you must pay for each emergency room visit before the Plan begins to pay benefits. Emergency Room visits have a $100 per visit deductible. This deductible will be waived if you are admitted to the hospital from the emergency room.

Coinsurance

The Plan pays a percentage of Covered Expenses, also known as Coinsurance. For PPO Providers, the Plan pays a percentage of the Contract Rate and the participants pays a percentage. For Non-PPO Providers, the Plan generally pays a percentage of the Scheduled Allowance. Some Hospitals may be contracted only for inpatient services or for specific outpatient services. For Hospital outpatient services, the determination of whether the Hospital will be paid as a PPO Provider, or a Non-PPO Provider depends on whether the Hospital is contracted for the services you receive.

Coinsurance Maximum for Covered Expenses

Coinsurance refers to how you and the Fund will split the cost of certain Covered Expenses. Once you've met your annual Deductible, the Fund generally pays a percentage of the Covered Expenses, and you (and not the Fund) are responsible for paying the rest. The part you pay is called the Coinsurance. There are limits on the amount of coinsurance you (and each of your Dependents) are responsible for paying in a calendar year. This is known as the Coinsurance Maximum or annual out of pocket limit. This benefit does not apply to retirees who reside outside of the state of Nevada. The following do not count toward the coinsurance maximum and will never be paid at 100%:

- Charges from a Non-PPO Provider
- Charges beyond a Scheduled Allowance
- Amounts you pay for excluded services or supplies.
- Your annual calendar year Deductible
- Dental or Vision Benefits

The following table outlines the differences between a Coinsurance Maximum and an Out-of-Pocket Maximum for a Non-Flat Rate Participant:

Hospitalization at a Contracted Hospital	$20,000 total charge
Contracted Rate	$15,000 (Contracted Hospital writes off $5,000)
Participant pays deductible, then 20% up to either Coinsurance Maximum ($10,000) or Out-of-Pocket Maximum, whichever occurs first	$250 annual deductible, plus First $10,000 x 20% Coinsurance = $2,000 * Participant's total payment is $2,250 *
Plan pays	After deductible and 80/20Coinsurance of first $10,000, then plan pays 100% for the remaining $4,750 = Plan Pays $12,750

* Please note that the most coinsurance that you could pay out of your own pocket (after the deductible is met) for Covered Expenses from a Contracted provider is $2,000 per person. This amount is known as your **Out-of-Pocket maximum.**

Retirees Who Reside Outside of the State of Nevada

After a covered retiree meets his/her deductible, the Plan pays 80% of the first $10,000 of covered expenses incurred by each participant in a calendar year. Thereafter, the Fund pays 100% of the contract rate for PPO Providers or 100% of the Scheduled Allowance for Non-PPO Providers for each participant for the remainder of the same calendar year.

If You Have Other Insurance

It is your responsibility to notify the Trust Fund Office if you have other insurance.
The other insurance inquiry form (which members are required to complete, sign, and submit to the Trust Fund Office at least once each calendar year) asks you whether you have other insurance. By entering the requested information on the form, you take care of your notification responsibility. You can find this form on 169laborers.com or at the Trust Fund office.

Maximum Plan Benefits

Types of Maximum Plan Benefits: There are two types of maximum amounts of benefits payable by the Plan on account of medical expenses incurred by any covered Plan Participant under this Plan. They are described in the following sections, and they are: Lifetime Maximum Plan Benefit and Annual Maximum Plan Benefit.

A **Lifetime Maximum Plan Benefit** is the maximum number of benefits payable by this Plan for a particular service/supply during the entire time a Plan Participant is covered under this Plan, regardless of any interruption in the continuity of coverage. Once the Plan has paid the Lifetime Maximum benefit for a Covered Individual, no further Plan benefits will be paid on account of that person for that non-essential service/supply. The description of the maximum as a "Lifetime" maximum does not mean, nor should it be construed to mean, that the Plan has any obligation to pay any benefits during the lifetime of the Plan Participant after coverage terminates. Services/supplies subject to a lifetime maximum include but are not limited to bariatric surgery, orthodontics, dental implants, and more information is provided later in this chapter. As excepted benefits, the Dental and Vision plans are still subject to lifetime maximum plan benefits for participants aged 18 and older.

An Annual Maximum Plan Benefit is the maximum number of benefits payable by this Plan each calendar year for certain Eligible Medical Expenses. Once the Plan has paid the Annual Maximum Plan Benefit for any of those services or supplies on behalf of any Covered Individual or family, no further Plan benefits will be paid for those services or supplies on account of that Individual or family for the balance of the Calendar Year. The services or supplies that are subject to an Annual Maximum Plan Benefit include but are not limited to the Chiropractic Benefit, and more information is provided later in this chapter.

Utilization Review Program

Whenever your Physician or other provider recommends an elective non-emergency hospital stay, bariatric surgery, home health care or home infusion services, treatment at a skilled nursing facility or other specialized facility including a residential treatment facility, Utilization Review from the Trust Fund is required. The provider must contact the Trust Fund on 1-775-826- 7200. Preauthorization tells you in advance about Plan coverage for an inpatient Hospital stay. You are responsible for obtaining preauthorization, although your Hospital or Physician may obtain it on your behalf.

The Trust Fund will determine the medical necessity of such hospital confinement, and if medically necessary, the number of authorized days for the confinement. No benefits are payable for days that are determined not to be medically necessary.

Utilization review is not required in connection with childbirth for a length of stay of less than 48 hours following a normal vaginal delivery or less than 96 hours following a Caesarean section, however precertification is needed for hospital stay.

WHAT SERVICES MUST BE PRECERTIFIED BY THE Plan?

- All Elective Hospital admissions. (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*).
    - Biopsy's
    - Botox
    - Cardiac Catheterization
    - Cat Scans
    - Chemotherapy
    - Colonoscopies-Age 44 And Under Require An Authorization-All Funds
    - CyberKnife
    - Epidurals-If Done At A Surgery Center Or Hospital
    - Genicular Blocks-Done In Any Setting
    - Home Health / Home Pt / Home Ot / Home St
    - Home Infusion Therapy
    - Infusion Therapy / Iv Therapy
    - Inpatient Admits
    - Inpatient Rehabilitation
    - Inpatient Skilled Nursing
    - Inpatient Surgeries
    - Kyphoplasty
    - Medial Branch Blocks-If Done In A Surgery Center Or Hospital
    - MRI's
    - MRA's
    - Nuclear Medicine Testing
    - Outpatient Surgery
    - Pain Pumps
    - Paracentesis
    - Pet Scans
    - Plexus Blocks-Done In Any Setting
    - Prosthetic Limbs
    - Radiation Therapy
    - Radiofrequency Ablation-If Done At A Surgery Center
    - Referral For A Transplant Of Any Type
    - Si Joint Injections-Any Location
    - Spinal Cord Stimulators-Trials & Implants
    - Thoracentesis
    - Tran Magnetic Stimulation Therapy
    - Transplants-Any And All Types
    - Vertebroplasty-Done In Any Setting
    - Wheelchairs

No prior authorization will be needed for **Urology Nevada's s**urgery center, **Surgery Nevada,** for procedures that would have been done previously in an office setting to now be done at the Surgery Center.

Precertification does not mean benefits are payable in all cases. No benefits are payable for days that are determined not to be medically necessary. Coverage depends on the services that are provided, your eligibility status at the time service is provided, and any benefit limitations.

In a medical emergency, you should seek the necessary treatment immediately.

1. The term "Emergency Services" means the following:/
2. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
3. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency room services are covered:

1. Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis.
2. Without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract emergency facility, as applicable, with respect to the services,·
3. Without imposing any administrative requirement or limitation on Non-Contract Provider Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract Providers and Contract emergency facilities,·
4. Without imposing cost-sharing requirements on Non-Contract Provider Emergency Services that are greater than the requirements that would apply if the services were provided by a Contract Provider or a Contract emergency facility.
5. By calculating the Cost-sharing requirement for Non-Contract Provider Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
6. By counting any Cost-sharing payments made by the participant or dependent with respect to the Non-Contract Provider Emergency Services toward any in-network deductible or in- network out-of- pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a Contract Provider or a Contract emergency facility.
7. Emergency Services furnished by a Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

    a. The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; and

    b. The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a non- Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

    c. The participant or dependent gives informed consent to continued treatment by the non- Contract provider, acknowledging that the participant or dependent understands that continued treatment by the non- Contract provider may result in greater cost to the participant or dependent.

Covered Expenses

- **Physician services**—If you or a covered Dependent requires the services of a Physician for an emergency medical condition within or outside the state of Nevada, benefits are paid at the same level as hospital benefits for emergency medical conditions.
- **Hospital emergency room** use, and the supplies, ancillary services, drugs, and medicines listed earlier under "Hospital Services and Supplies."
- **Hospitalization** (including acute care Medically Necessary detoxification)- If you are admitted to a Non-PPO Hospital in an emergency, the Fund will pay the percentage listed in the Schedule of Medical Benefits beginning on page 19. If you decline to transfer to a PPO Hospital after it has been determined to be medically safe, benefits for any services after that point will be paid at the Non-PPO Fee Schedule.
- **Ambulance service**—services of a licensed ambulance for the ground transportation of you or your covered Dependent to a Hospital. A licensed air ambulance is also covered if the Board determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life.

Covered Non-Emergency Services

With regard to non-emergency items or services that are otherwise covered by the Plan, if the covered non-emergency items or services are performed by a non-Contract provider at a Contract facility, the items or services are covered by the plan with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract provider, calculated as follows:

- By calculating the cost-sharing payment as if the total amount that would have been charged for the items and services by such Contract provider were equal to the Recognized Amount for the items and services, and
- By counting any cost-sharing payments made by the participant or dependent toward any in- network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the saine manner as if such cost-sharing payments were made with respect to items and services furnished by a - Contract Provider.
- Non-emergency items or services performed by a Non-Contract Provider at a Contract facility will be covered based on your out-of-network coverage if:
- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and
- The participant or dependent gives informed consent to continued treatment by the Non- Contract Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract Provider may result in greater cost to the participant or dependent.
- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria, and therefore these services will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider,
- With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a Contract Provider.

Continuing Care

If you are a Continuing Care Patient, and the contract with your Network provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers' and/or facilities' participation in the plan:

- You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
- If you elect, you will be allowed ninety (90) days of continued Plan coverage, or until treatment ends sooner, at Network cost sharing to allow for a transition of care to a Network provider.

Furthermore, the provider/facility has to accept payment from the Plan (and cost-sharing payments from the patient) for the course of treatment of a continuing care patient at the previously agreed-upon payment for up to 90 days and the provider/facility has to adhere to all policies, procedures and the Plan rules for items or services as if the termination had not occurred for 90 days.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims should be submitted to the Plan within 90 days from the date of service. No Plan benefits will be paid for any claim submitted one year or more after the date of service.

See also the Claim Filing and Appeal Information chapter 13 for more information. Also review the section toward the end of that chapter 13 on “Limitation On When A Lawsuit May Be Started” in Chapter 13.

Covered Services and Supplies

Covered services and supplies include those described below. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the "Exclusions from Coverage" that follow the covered services and supplies. Covered services and supplies are limited to those that are Medically Necessary, not excluded, not in excess of a Lifetime Maximum Plan Benefit, must be incurred while you are covered under the Plan, and are for the diagnosis or treatment of an injury or illness or are preventive care as outlined below.

Unless noted otherwise, any limits on days, visits, or specific services mentioned below are for all of your Injuries or Illnesses combined.

Hospital Services and Supplies (Inpatient)

Covered expenses include the following when medically necessary:

- Room and board facility fees in a semi-private room with general nursing services, including specialty care units such as cardiac care units and intensive care units.
- Routine nursery care is furnished to a newborn baby while the mother is also confined in the Hospital.
- Use of operating, delivery, and cystoscopy rooms
- Supplies and Oxygen
- Ancillary services, including laboratory, cardiology, pathology, and radiology and any professional component of these services.
- Anesthesia
- Physical therapy while the participant is confined. (Outpatient Physical Therapy benefit is described below)
- In a PPO Hospital, drugs and medicines approved for general use by the Food and Drug Administration that are supplied by the hospital for the Illness, Injury, or condition for which the eligible individual is hospitalized, including take-home drugs dispensed by the hospital's pharmacy at the time of discharge.
- In a Non-PPO Hospital, drugs and medicines approved for general use by the Food and Drug Administration that are supplied by the hospital for use during the eligible individual's stay.
- Blood transfusions (including autologous blood transfer), including the cost of un-replaced blood, blood products, and blood processing.

The documented assignment of a patient to a hospital bed for diagnostic watching or observation during which time the patient does not receive any therapeutic or surgical intervention, an Observation Short Stay, is considered an inpatient stay only when the patient remains in a hospital bed after the hour of midnight. The Hospital shall be reimbursed at the appropriate inpatient rate for all services rendered after the hour of midnight for this type of inpatient confinement. All of the following days will also be considered at the appropriate patient rate.

Benefits for hospital stays are paid as shown in the following chart.

PPO Hospital	80% of the Contract Rate, after $250 Deductible
Non-PPO Hospital	50%-60% of the Scheduled Allowance, after $250 Deductible

Exception: For Non-PPO Provider Emergency Services, non-Emergency Services provided by Non-PPO Providers at PPO facilities, and Non-PPO Air Ambulance services, the Allowed Charge is the Recognized Amount or the Out-Of-Network Rate when a claim is resolved by settlement agreement or Independent Dispute Resolution (IDR) under the No Surprise Billing Act ("NSA").

Benefits for expense incurred and billed by the Hospital for the following:

- Emergency room services ($100 deductible per emergency room visit is required and payment must be made at the time of service. The $100 co-pay will be waived if the participant is admitted to the hospital from the emergency room.)
- Facilities for the following major procedures:

— Cardiac catheterization.

— Phlebotomy services required to be done in an acute care facility.

— Blood transfusions.

— Diagnostic procedures requiring an acute care facility.

- Outpatient surgery (See Special Outpatient Surgery Benefits on page 32, for additional information on specific services)
- Other laboratory, x-ray, imaging and other diagnostic procedures (See X-Ray and Laboratory Services on page 32 for additional information on diagnostic imaging and laboratory procedures).

Limitations

Emergency Room Facility charges and Emergency Room physician's charges will not be covered by the plan if services are only for prescription(s).

If you are having outpatient surgery at Renown Regional Medical Center or Renown South Meadows Medical Center, you may get your preoperative testing at the respective hospitals on the day of your outpatient surgery, and the diagnostic resting required for the surgery will be part of the outpatient surgery charge. However, if outpatient preoperative testing is done prior to the date of the surgery, you may be billed separately and incur additional costs.

Special Trauma Benefit

Medically necessary services received at the Renown Regional Medical Center Trauma Unit will be paid at 100% of Contract Rate when the following requirements are met:

1) There has been pre-hospital notification based on triage information from pre-hospital caregivers; and
2) The participant meets either 1) local, state, or American College of Surgeons' field of triage criteria; OR 2) the participant is delivered by inter-hospital transfer; and
3) The participant is given the appropriate team response.

Services received at a facility that is not the Renown Regional Medical Center Trauma Unit, or participants who do not meet the above requirements, will be covered as otherwise provided in this Plan but will not receive the above-described Special Trauma Benefit.

Skilled Nursing Facility or Other Specialized Facility

The Plan will reimburse up to 80% of the semi-private room accommodation. Conditions of eligibility for benefits are as follows:

- Precertification by the Plan is required.
- Services must be those which are regularly provided and billed by the skilled nursing facility or other specialized facility.
- The services must be consistent with the Illness, Injury, degree of disability, and medical needs of you or your covered Dependent, as determined by the professional review organization. Benefits are provided only for the number of days required to treat the Illness or Injury. You or your Dependent must remain under the active medical supervision of a Physician. The Physician must be treating the Illness or Injury for which you or your Dependent is confined in the skilled nursing facility or other specialized facility.

Covered Expenses

- Accommodation in a room of two or more beds, or, if a private room is used, the Contracted Rate or the Non-PPO Fee Schedule for two-bedroom accommodation in that facility.
- Special treatment rooms
- Laboratory exams
- Physical, occupational, and speech therapy
- Oxygen and other gas therapy
- Drugs and medicines approved for general use by the Food and Drug Administration that are used in the facility.
- Blood transfusions, blood products, and blood processing

Not Covered

- Custodial Care is not covered.

Doctor Visits

Covered Expense

- Visits to a Physician's office (including a specialist) for diagnosis or treatment of an Illness or Injury.
- Visits by a Physician while you are confined in a hospital.
- Visits by a Physician to your home for diagnosis or treatment of an Illness.
- For the prenatal care/pregnancy of an Employee or spouse.

Not covered

- More than one home or office "visit" per day by a Physician. The term "visit" means a personal interview between the Eligible Individual and the Physician and does not include telephone calls or other situations where a Physician does not personally examine the Eligible Individual. This one visit exclusion does not apply to additional medically necessary services that are otherwise covered under the Plan which are performed during the same day and/or visit for a covered preventive service. Dependent child pregnancies.

Physical Therapy (Outpatient)

Services of a registered physical therapist required for the treatment of an acute medical condition and prescribed by a Doctor of Medicine or Doctor of Osteopathic Medicine, based on medical necessity.

Physical Therapy is limited to 30 visits per calendar year.

Diabetes Instruction Program

The Plan provides for a Diabetes instruction program supervised by a Physician, designed to teach the person and his family about daily management of diabetic therapy.

X-Ray and Laboratory Services

Covered Expense

- Outpatient diagnostic radiology and laboratory services

Limitation

- For a Non-PPO Provider performing only the professional component (Modifier 26), the Covered Expense is 40% of the Scheduled Allowance.

Second Surgical Opinion

There is usually more than one method of treatment for a disease or illness -- surgery is not necessarily the best method of treatment. Therefore, it is often best to seek a second opinion. The second opinion consultants will take into account factors that influence your risk for having surgery such as age, blood pressure, and general health. If surgery is the best option for you, having it confirmed by a specialist will give you peace of mind.

Covered Expense

- a second surgical consultation obtained for the purpose of determining the necessity for prescribed elective surgery. Subject to calendar year deductible payable at 80% of contract rate or 60% of the Non-PPO Provider Scheduled Allowance.

Surgery (Inpatient)

Covered Expenses

- Professional services by a primary operating Physician or assisting surgeon. Services by a second Physician or surgeon on the same case at the same time when the attendance is warranted by a need for supplementary skills. As medically necessary based on Medicare Guidelines.

Preoperative and Postoperative Care: Benefits will be based on the Contract Rate, or the Scheduled Allowance.

If you are scheduled for inpatient surgery at Renown Regional Medical Center or Renown South Meadows Medical Center, you may get your preoperative testing at the respective hospitals three days prior to the surgery and the charges will be part of your hospital bill. However, if the preoperative testing is done more than three days prior to the date of the surgery, you may be billed separately and incur additional costs.

Note about multiple procedures: If an incidental procedure is performed through the same incision, the benefit will be based on the major procedure only. If multiple or bilateral procedures are performed at the same time that add significant time or complexity, they will be payable as follows: 100% of the Scheduled Allowance for the major procedure, 50% for the second procedure, 25% for the third procedure, 10% for a fourth procedure, and 5% for each successive procedure. Subsequent procedures for surgery or repair of a dislocation or reduction of a fracture that are performed at the same time and that add significant time or complexity are limited to 50% for the second procedure and 25% for the third procedure.

- For an Employee or dependents, obstetrical services and operations for extra-uterine pregnancy, or miscarriage (for employee or dependent spouse only, except for Complications of Pregnancy).
- Consistent with the Women's Health and Cancer Rights Act of 1998, reconstruction of the breast on which a mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- Services of a Registered Nurse First Assistant (RNFA), Physician's Assistant (PA), Certified Orthopedic Technician (COT), or Certified Surgical Assistant (CSA) in lieu of an assistant surgeon are allowed at 15% of the allowance for the primary surgeon.
- Services of an anesthetist. (When regional or general anesthesia-not including local infiltration anesthesia-is provided by a primary operating or assisting Physician, the Covered Expense is determined by the "basic" value for anesthesia without added value for time).
- Organ and tissue transplant surgery for cornea, bone marrow, kidney, heart, heart-lung, lung, liver and pancreas as described in the Section "Transplants."
- Pain Management Epidurals require prior authorization if being done in an outpatient facility.

Not Covered

Surgery solely for cosmetic purposes or other services for beautification, except

- to correct congenital anomalies,
- to correct functional disorder.

Maternity and Reproductive Services

The Fund pays benefits as noted below for Covered Expenses.

Covered Expense

- Obstetrical services, including operations for extra-uterine pregnancy, miscarriage on the same basis as other surgery.
- Prenatal care on the same basis as other Physician services
- Hospital stays for mother and newborn on the same basis as other hospital stays.
- Sterilization
- Erectile dysfunction surgery
- FDA approved contraceptives that are not prescription drugs. Please see Chapter 4: Prescription Drug Benefits for information on benefits for prescription drug contraceptives.

See also "Well childcare" under "Preventive Care" below for information on routine nursery care in the hospital furnished to a newborn baby while the mother is an inpatient.

Not Covered

- Services of a Midwife
- Expenses for more than one voluntary termination of Pregnancy per Employee and/or dependent spouse per lifetime, unless necessary to save the life of the woman having the abortion or to avert substantial and irreversible impairment of a major bodily function of the woman having the abortion.
- Services to reverse voluntary surgically induced infertility.
- In vitro fertilization, artificial insemination, or any other surgical services to induce pregnancy or related to infertility or any drug or injection therapy or other services to induce pregnancy.

- Dependent child pregnancies are not covered. Medically necessary services to treat complications of a dependent child pregnancy cover the same as any other illness.
- Surrogacy or Surrogate pregnancy (including but not limited to traditional surrogacy, or gestational surrogacy/carrier.)

Special Outpatient Surgery Benefits

For the outpatient surgical procedures performed by a PPO Provider at specific facilities, subject to the deductible, the coinsurance percentage is 80% of the Contract Rate. If the surgical procedure is performed by a Non-PPO provider or at a Non-PPO facility, benefits are 60% of the Scheduled Allowance, following satisfaction of the deductible. Outpatient Surgery requires precertification.

Covered Expenses for outpatient surgery include the applicable surgical care, the professional services of Physicians and surgeons, charges for any necessary laboratory work, x-rays, facilities, services and supplies in connection with the surgery and done on the same day as the procedure. However, no benefit will be payable for charges incurred for: (a) room and board, or (b) the use of facilities (such as an operating room or a recovery room) in connection with the performance of surgical procedures in a doctor's office.

Outpatient Surgery Center Benefit for Dental Restorations under General Anesthesia

Dental restorations under general anesthesia will be covered for children under age 6. This will cover general anesthesia, and the outpatient facility fees as regular medical plan benefits. Dentist charges will be considered under the Dental Plan. Exceptional circumstances may apply for patients with concurrent medical conditions or severe disability, and these will be considered on a case-by-case basis.

Preventive Care

The Fund pays benefits as noted below for Covered Expenses.

Covered Expense

- Physical examination (Employee or Spouse)- The Fund will reimburse you for expenses for a routine physical examination performed by a Physician. This benefit includes one basic X-ray, one Coronary Calcium CT, one EKG, and up to ten routine laboratory tests. Immunizations are not included in this benefit; the below immunizations are covered and will allow the following annual dollar limit.
- Adult Immunizations (not subject to Deductible or Coinsurance):
- Up to $33 for a flu shot.
- Up to $224 for a Pneumococcal vaccine
- Up to $172 for a Shingles vaccine per shot (2 per year)
- Up to $320 for RSV vaccine for adults
- Annual routine pap smear and pelvic examination
- Annual routine mammogram for women aged 35 and older.
- Colonoscopy once every five years, over age 45.
- Well-childcare up to age 19, includes immunizations.
- School physicals for dependent child under age 19, reimbursement of max of $70 for NON-PPO.
- Routine diagnostic testing or routine childhood vaccinations, in accordance with the "Recommendations for Preventive Pediatric Health Care" published by the American Academy of Pediatrics up to age 19.
- HPV (Human Papilloma Virus) vaccine and lab test for dependents under age 19.

Not Covered

- Physical examinations for dependent children over the age of 19.
- Routine eye examinations for visual acuity except as described under Vision Benefit
- Any examination required by an employer as a condition of employment or Department of Transportation physicals.

Transplants

The Fund will pay regular Plan benefits for covered transplant expenses, provided the transplant is not considered experimental or

investigational and the transplant is performed in a transplant center program in a major medical center approved either by the Federal government or the appropriate state agency of the state in which the center is located.

The Fund pays benefits for transplants of the following organs and tissues:

- cornea,
- bone marrow,
- kidney,
- heart,
- lung,
- heart-lung,
- liver, and
- pancreas.

Covered Expense

- Patient screening
- Organ procurement and transportation of the organ
- Surgery for the patient
- Follow-up care in the home or a hospital
- Immunosuppressant drugs
- The donor's medical expenses, up to $5,000 per lifetime, if the donor is without other group insurance.

Treatment for Chiropractic Services

PPO covered at 80% after deductible. If you use a Non-PPO Provider, in state Non-PPO chiropractic visits are limited to $21.98 per visit and for out of state Non-PPO chiropractic visits are limited to $25.20 per visit.

Covered Expense

- Treatment of the vertebrae, spine, back, or neck by a Physician, chiropractor, or other licensed practitioner, for up to 30 visits per calendar year for all conditions combined.

Mental Health

Benefits for outpatient mental health care are provided to you and your Dependents. Benefits are payable at the same coinsurance percentage as any other office visit. Family and marriage counseling may also be covered.

Inpatient mental health treatment is available to you and your Dependents as described in the Schedule of Medical Benefits (payable at the same coinsurance percentage as any other inpatient confinement).

A diagnosis of an eating disorder (such as anorexia or bulimia) is considered a mental health diagnosis. Available benefits may include (but are not limited to) outpatient services such as psychotherapy, partial day hospitalization, and medically necessary nutritional counseling, as well as inpatient treatment. Benefits for eating disorders are payable the same as any other illness.

Covered Expenses

- **Inpatient Treatment**
- **Outpatient Treatment**. Psychotherapy and psychological testing provided by a covered practitioner practicing within the scope of his or her license. (No deductible applies)
- **Recovery Home/Halfway House/Residential Treatment Program**
- **Diversion/Education**
- **Telemedicine Services** for treatment of mental health and/or substance use disorder.

Substance Use Disorder Treatment

Eligible Individuals may receive treatment for a substance use disorder. The Fund will pay benefits for the treatment described below, based on the setting in which treatment is provided.

Covered Expense

- **Inpatient Treatment:** For Medically Necessary services, coverage is provided the same as any other inpatient stay and is covered at the coinsurance percentages outlined in the Schedule of Medical Benefits.
- **Outpatient Treatment (including intensive outpatient treatment and partial hospitalization):** For Medically Necessary services, coverage is provided the same as any other outpatient service and is covered at the coinsurance percentages outlined in the Schedule of Medical Benefits.
- **Recovery Home/Halfway House/Residential Treatment Program:** For Medically Necessary services, coverage is provided at the coinsurance percentages outlined in the Schedule of Benefits.
- **Diversion/Education.** For Medically Necessary services, coverage is provided at the coinsurance percentages outlined in the Schedule of Benefits.

Home Health Care and Infusion Therapy

Benefits for home health care or home infusion therapy will not exceed those that would have been payable if services were performed in a hospital or skilled nursing facility or other specialized facility. Services MUST be preauthorized.

Covered Expenses

- Home health care or home infusion therapy that would have been covered under the Plan if services were performed in a hospital or skilled nursing facility or other specialized facility and that meets the following requirements:
- Services are prescribed by a Physician to be performed in your home and are medically necessary.
- Services are for care and treatment of an Illness or Injury immediately following a period of confinement in a hospital or skilled nursing facility or other specialized facility and are provided in lieu of confinement.
- Services are performed by or under the supervision of a person or agency that is licensed, certified, or otherwise qualified to perform such services on the same basis as if the services had been performed in a hospital or skilled nursing facility or other specialized facility.
- Periodic recertification of the necessity for such services and prognosis reports are furnished by the home health care agency and/or the Physician when requested by the Fund.

Not Covered

- Custodial services to assist in meeting personal, family, and/or domestic needs.

Hearing Aids

The Fund will reimburse 50% of the Contract Rate or 50% of Non-PPO Provider Scheduled Allowance incurred for the hearing aid devices/hearing exam performed by a physician and placement of hearing device. The Plan will not cover hearing tests that are not in conjunction with the placement of Hearing aid(s).

Covered Expense

- A hearing examination performed by a Physician (i.e. MD. or certified Audiologist) for placement of a hearing aid device.
- The hearing aid device is limited to one device per ear during every three years.

Durable Medical Equipment (DME), Prostheses, and Orthotics

Covered Expenses

- Rental or purchase of medical equipment and supplies that are ordered by a Physician, are manufactured specifically for medical use, are of no further use when the medical need ends, are usable only by the patient, and are approved as effective treatment of a condition.
- Oxygen and rental of equipment for its administration (small or large)
- Fees incurred for maintenance agreements related to the purchase of oxygen concentrators.

- Artificial durable devices or equipment that replaces all or part of a bodily organ or that improves the function of an impaired

bodily organ (including prostheses following a mastectomy), except dental appliances, which are not covered under medical benefits.

- Blood glucose meters for diabetes
- Custom-molded orthotics when provided by a Doctor of Medicine (M.D.), Doctor of Osteopathic Medicine (D.O.), or podiatrist (D.P.M.) and must be ordered by a M.D., D.O. or D.P.M. for treatment of the feet.

Not Covered

- Rental or purchase of equipment that is primarily for the comfort or hygiene of the patient, is for environmental control, is for exercise, for modifications to the home or automobile, or is for prevention purposes (example humidifier, back swing, etc.).
- Rental charges that exceed the reasonable purchase price of the equipment.
- Expenses for repairs of custom-molded orthotics.
- Orthopedic shoes (except when joined to braces) or shoe inserts, unless when medically necessary.
- Replacement of prostheses except in cases of clearly demonstrable medical necessity due to significant clinical change in the functional status of the patient or if the prosthesis becomes nonfunctional due to normal, predictable wear and tear that cannot be repaired.
- Coverage for the replacement of a previously purchased prosthetic device is not covered if it merely is to “upgrade" to a model with superior enhancements (example microprocessor-controlled limb prostheses like Intelligent Prosthesis and the C-LEG ®).

Acupuncture

Covered Expenses

- Medically necessary treatment for up to 15 visits per calendar year subject to the calendar year deductible.

Bariatric Surgery

The Plan will pay for any services related to Bariatric Surgery provided it is deemed Medically Necessary as defined by "Medicare Bariatric Surgery Policy Guidelines." This service requires preauthorization prior to surgery. Furthermore, Bariatric Surgery is limited to (1) one procedure per lifetime. All other weight reduction procedures are excluded.

Covered Expenses.

- Services will include but are not limited to pre-surgery labs, office visits, surgeon, anesthesia, facility and any follow up services that may be required up to the lifetime maximum benefit.

Hospice Care

The Plan will pay 90% of the Scheduled Allowance or 90% of Contract Rates for Hospice Care and services performed by an approved Hospice Agency for a terminally ill Participant and family unit. "Terminally ill" means that the patient has a life expectancy of six months or less. The "family unit" means the eligible members of the terminally ill Participant's immediate family.

Respite Care

Hospice Care benefits are payable only for Covered Expenses incurred during a period for which the Plan validates a Physician's certification the Participant is terminally ill, and during the bereavement period. Covered Expenses (except bereavement counseling) are reimbursed as follows:

PPO Provider:	90% of the Contracted Rate
Non-PPO Provider:	50% of the Scheduled Allowance

Covered Expenses will include only the following items:

1) Inpatient confinement in a Hospice, for up to a total of 8 days of inpatient Respite Care. Respite Care is care that is furnished a terminally ill Participant so that the dependents may have relief from the stress of caring for the terminally ill Participant.
2) the following Home Health Care services:
    a) professional services of a registered nurse, a licensed practical nurse, or a licensed vocational nurse.
    b) services of a home health aide.
    c) rental (but not repair or replacement) of durable medical equipment.
    d) laboratory services, medical supplies, oxygen, drugs and medicines prescribed by a Physician; and

e) nutritional counseling and special meals.

3) Medical Social Services furnished to a terminally ill Participant and his or her eligible dependents. Medical Social Services means those counseling services furnished by psychiatrist, psychologist or staff member of a licensed social services agency.

4) Bereavement counseling by a licensed or certified social worker or licensed Pastoral counselor to assist the eligible participants during the Bereavement Period in coping with the death of the terminally ill Participant. Covered Expenses are reimbursed at 90% of Contract Rate for PPO Providers, or 60% of Scheduled Allowance for Non-PPO Providers.

Additional Services and Supplies

Covered Expenses

- Services of a registered nurse or licensed vocational nurse when these services are medically necessary.
- Physical therapy required for the treatment of a medical condition and prescribed by a Physician showing the frequency and duration of the physical therapy. 30 visits max per calendar year.
- Surgical dressings, splints, casts, and other devices for reduction of fractures or dislocations.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.
- Radiation therapy and chemotherapy.
- Temporomandibular Joint (TMJ) Syndrome. Regular Plan benefits for treatment of TMJ are payable.
- Epidurals for pain management.
- Trigger point injections for up to five trigger point injections per visit (limited to one visit per day) and a maximum of 15 visits per calendar year.
- Two support hose stockings are covered per calendar year if it is medically necessary and supported by doctor's orders.
- Following cataract surgery, the first lens replacement is covered under the medical plan.
- Allergy Services, Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. Desensitization and hypo sensitization (allergy shots given at periodic intervals). Allergy antigen solution.
- Cardiac Rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.) with or without percutaneous transluminal coronary angioplasty (PTCA).
- Circumcision for newborn males from birth to 10 weeks of age, and thereafter, only if it is determined to be Medically Necessary.
- Wigs, if prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of:
  - Burns resulting in permanent alopecia.
  - Lupus
  - Fungal infections not responding to a course of anti-fungal treatment resulting in near or complete cranial hair loss.
  - Chemotherapy
  - Radiation therapy
- Wigs (including repair and replacement) will be covered for eligible participants who meet the above criteria, one per three (3) years.

Not Covered

- Physical therapist services that are primarily educational, sports-related, or preventive, such as physical conditioning, exercise, or "back school".

Exclusions from Coverage

In addition to the services shown as "Not Covered," no medical benefits are payable for the following:

- Any expenses that

— exceed the Non-PPO Provider Scheduled Allowance

— are for services and supplies that are not deemed "medically necessary," or

— are incurred by you or a dependent on a date you are not covered by the Plan (an expense is deemed to have been incurred on the date the person receives the service or supply for which the charge is made).

Definitions of "medically necessary," and other terms used in this section can be found in the glossary at the end of this SPD.

- Any services or supplies listed as "Not Covered" in relation to specific benefits earlier in this chapter.
- Services for which benefits are payable under any other programs provided by the Fund.
- Any course of treatment, whether or not prescribed by a physician, for which charges incurred are not the direct result of an Injury or illness, any procedure not recognized to have medical significance or therapeutic value, and/or any course of treatment making use of drugs or devices that are experimental or investigational (see the glossary at the end of this SPD for definitions of "experimental" and "investigational").
- Experimental treatment (see the glossary at the end of this SPD for a definition of "experimental").
- Services furnished by a naturopath or any other provider not meeting the definition of Physician or other allied health care professional (see the glossary at the end of this SPD for a definition of "Physician").
- If this Plan is secondary when coordinating benefits with another plan that has entered into a preferred provider agreement with a medical or hospital provider, any amount exceeding the difference between the normal charges billed for the expenses by the provider or the contractual rate for such expense under the preferred provider agreement (whichever is less) and the amount that the other plan pays as primary. (This exclusion is in addition to any other limits generally applicable to this Plan or its coordination of benefit provisions.)
- Custodial care or rest cures; services provided by a rest home, a home for the aged, long term care facility, or any similar facility; or custodial hospital care.
- Dental plates, bridges, crowns, caps, or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except treatment for tumors or cysts or treatment necessary to repair or alleviate damage to natural teeth (see Chapter 5: Dental Benefits, for information on coverage of such benefits).
- Optometric services, vision therapy including orthoptics (except for esotropia, exotropia or strabismus), routine eye exams, eye refractions, eyeglasses (except the first pair of eyeglasses following eye surgery) or eyeglass fitting (see Chapter 6, Vision Care Benefits, for information on coverage of such benefits).
- Any surgical procedure to correct nearsightedness or farsightedness. Eye surgery for refractive error, such as LASIK.
- Charges made by a Participant's relative or a member of the Participant's household unless that person is first properly enrolled as a dependent.
- Expenses for transportation of physicians or family members.
- Educational services, supplies, or equipment, except the Diabetes instruction program.
- Food supplements or substitutes.
- Hypnotism, stress management biofeedback, and any goal-oriented behavior modification therapy, such as to cease smoking, lose weight or control pain.
- Anger management therapy and court ordered anger management therapy.
- Services provided primarily for weight reduction or treatment of obesity (except as specifically provided under the plan, see Bariatric Surgery).
- Surrogacy or Surrogate pregnancy (including but not limited to traditional surrogacy, or gestational surrogacy/carrier).
- Expenses incurred for office visits or surgical assistance performed by a nurse (A.P.N., R.N., L.P.N., or L.V.N.).
- Amounts in excess of any lifetime maximum (on an individual benefit).
- Any expenses for services or supplies for which a third party pays or is liable to pay due to any recovery, whether by settlement, judgment or otherwise.

- Dietitian services (except when treating a mental health disorder)
- Genetic testing
- Habilitative services
- Naturopathic/nephropathic substances/supplies
- Hemodialysis or peritoneal dialysis and supplies

General Plan Exclusions

The Fund will not provide benefits for the following:

- Services for which you are not legally obligated to pay or are not charged (or would not be charged, if you did not have insurance), except services received at a non-governmental charitable research hospital that meets all of the following criteria:

— It is internationally known as being devoted mainly to medical research.

— At least ten percent of its yearly budget is spent on research not directly related to patient care.

— At least one-third of its gross income comes from donations or grants other than gifts or payments for patient care.

— It accepts patients who are unable to pay.

— Two-thirds of its patients have conditions directly related to the hospital's research.

- Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any Workers' Compensation, employer's liability law, occupational disease law, or similar law; (If the right to recover such benefits is disputed, the Fund will provide benefits if you sign an agreement to prosecute a claim for such benefits diligently, consent to a lien by the Fund against your compensation for these benefits, and otherwise cooperate in securing reimbursement for the benefits provided.)
- Conditions caused by or arising out of

— an act of war, armed invasion, or aggression

— Intentional, self-inflected injuries. This does not exclude coverage for self-inflicted injuries (or injuries resulting from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries arise as a result of a mental health condition.

- Except to the extent benefits are required by Federal law to be provided by the Fund, any services provided by a local, state, or Federal government agency, or any services for which payment may be obtained from any such agency (except Medicaid)
- Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision.
- Any Illness, injury, disease, or other condition incurred during the commission by the claimant of a misdemeanor or felony crime of driving under the influence of intoxicating liquor or controlled or prohibited substance, unless arising as a result of a mental health condition. If the participant or eligible dependent had a concentration of alcohol in his blood or breath or had an amount of a prohibited or illegal substance in his blood or urine that exceeded the legal driving limit of the jurisdiction in which he was driving, then this exclusion shall apply even if the Participant or eligible dependent has entered a nolo contendere plea.
- Any illness, injury, disease, or other condition incurred during the commission by the claimant of a felony or aggravated assault by the participant or eligible dependent seeking benefits, unless arising as a result of a or mental health condition. If a participant or eligible dependent has been charged with the commission of a felony or aggravated assault then this exclusion shall apply, and this exclusion shall continue to apply if the Participant or eligible dependent has entered a nolo contendere plea as to any felony or aggravated assault.
- Any other expense specifically limited or excluded elsewhere in this booklet.

How to File a Claim for Medical Benefit Types of Claims

There are six types of claims applicable to the benefits described in this booklet. The following four types of claims are

health benefit claims (including claims regarding your medical, prescription drug, dental, and/or vision care benefits):

1. **Pre-service claim:** A claim for a benefit for which the Plan requires Precertification or Prior Authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

2. **Urgent care claim**: A claim for medical care or treatment is an urgent care claim if you want approval of the benefit in advance and applying the time frames for a regular pre-service claim (15 to 30 days for an initial determination) and

- could seriously jeopardize your life or health or your ability to regain maximum function or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.
- The Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above, will be treated as an urgent care claim.

3. **Concurrent care claim:** A concurrent care claim is a decision on a treatment in progress that could result in a reduction, termination, or extension of a benefit. In this situation, a decision to reduce or terminate treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend approved urgent care treatment.

4. **Post-service claim**: Any other type of health care claim is considered a post-service claim--for example, a claim submitted for payment after health services and treatment have been obtained.

5. The other two types of benefit claims under this Plan are as follows:

Disability claims: A disability claim is a claim for weekly disability benefits or a claim for a determination of disability (for example, for extended life insurance coverage during a period of disability).

Other claims: The category "other claims" includes claims for employee and dependent life insurance, and employee AD&D insurance benefits.

What is NOT a "Claim"

The following are not considered claims and are thus not subject to the requirements and timelines described in this section:

1. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim.
2. A request for an advance determination regarding the Plan's coverage of a non-urgent medical treatment or service recommended by your physician (Note, however, that getting such an advance determination does not guarantee payment of Plan benefits. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid)
3. A prescription you present to a pharmacy to be filled (However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section.)

How to File Urgent Care Claims

If your Physician or other healthcare provider recommends prompt medical attention or treatment your case may qualify for urgent care claim handling if waiting for precertification:

- could seriously jeopardize your life or health or your ability to regain maximum function or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

(The physician can determine that yours is an urgent care claim, or the Plan can do this, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.)

You should fax the proposed treatment to the attention of the Utilization Review representative at (775) 826-7289, requesting approval of the benefit in advance. Do NOT submit a claim involving urgent health care via the U.S. Postal Service.

How to File Concurrent Claims

A concurrent care claim is a decision on a treatment in progress that could result in a reduction, termination, or extension of a benefit. In this situation, a decision to reduce or terminate treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend approved urgent care treatment.

You may file a concurrent claim by writing (or orally for an expedited review) to the Appropriate Claims Administrator (the

Trust Fund Office for medical, dental, and visions care, or OptumRx for prescription drug claims) whose contact information is listed on the Quick Reference Chart in this document.

If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.

How to File Post-Service Claims

NOTE: The discussion below applies to 'post-service claims"-claims you submit after you have received a service. The following are also considered claims: requests for expedited approval in cases meriting treatment as urgent care claims and decisions regarding treatment in progress. See "Urgent Care Claims" earlier in this Chapter 3 and Chapter 13: Claims Appeal Procedures for more information.

If you use a PPO Provider, the provider will usually file a claim for you. If you use a Non-PPO Provider, you may need to file a claim yourself.

To file a claim for health benefits, follow these steps:

- Obtain a claim form from the Trust Fund Office. (If it is not possible for you to get a Plan claim form, forms supplied by hospitals and physicians are usually acceptable substitutes for claim processing.)
- Complete your portion of the form, including information about other insurance coverage and accident information, if needed.
- Have the person providing services complete the rest of the form as applicable.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized.

The following information should be indicated on the bills or claim form submitted:

- Your (the employee's) name, address and Social Security number.
- The patient's name and date of birth and relationship to you.
- The date of service.
- The codes for the service(s) performed.
- The billed charge(s).
- The number of units (for anesthesia and certain other claims).
- The Federal taxpayer identification number (TIN) of the provider.
- The billing name and address of the provider.
- If health benefit services were rendered because of an accident, the date and place of the injury, including details (i.e., automobile accident, fall, etc.).

Mail your claim form with your itemized bills to the Northern Nevada Laborers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

- Mail any further bills or statements for any services covered by the Plan to the Northern Nevada Laborers Health and Welfare Trust Fund as soon as you receive them.

If you have any questions about submitting your claim, contact the Trust Fund Office.

Using an Authorized Representative

An authorized representative, such as your spouse, may complete the claim form and/or claim appeal for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. Even if you have designated an authorized representative to act on your behalf, you must personally sign a claim form and file it with the Trust Fund Office at least annually.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim without your having to complete the special authorization form.

When Claims Must Be Filed

All claims should be filed within 90 days following the date of service. The claim must be received within one (1) year from the date on which expenses were incurred.

Your claim will be considered to have been filed as soon as it is received at the Trust Fund Office.

An urgent care claim must be filed before services are obtained. (NOTE: Urgent care is not the same thing as emergency care. See Emergencies earlier in this Chapter 3 for information on what to do when you need emergency care.) If your urgent care claim has been improperly filed, the Trust Fund Office will notify you as soon as possible but no later than 24 hours after receipt of the claim of the proper procedures to be followed in filing a claim (provided the claim includes your name, your specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested). Unless the claim is re-filed properly, it will not constitute a claim.

A concurrent care claim to extend approved urgent care must be filed at least 24 hours before the approved treatment expires.

Timing of Initial Claims Decisions

The Trust Fund Office will make a determination of your claim within the following time frames.

1. **Urgent care claim**: You will be notified of a determination by telephone as soon as possible, taking into account the medical exigencies of your situation, but no later than 72 hours after receipt of the claim by the Trust Fund Office. The determination will also be confirmed in writing.

   If your urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Trust Fund Office will notify you as soon as possible, but no later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 2 working days. If the information is not provided within that time, your claim will be denied. Notice of a decision will be provided no later than 48 hours after the Trust Fund Office receives the specified information, but only if the information is received within the required time frame.

2. **Concurrent care claim**: A reconsideration that involves the termination or reduction of payment for a treatment in progress (other than termination or reduction of a benefit by Plan amendment or termination) will be made by the Trust Fund Office as soon as possible, but in any event early enough to allow you to have an appeal decided before the reduction or termination takes place.

A request by you to extend approved urgent care treatment will be acted upon by the Trust Fund Office within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

3. **Post-service claims**: Ordinarily, you will be notified of the decision on your post-service health care claim within 30 days of the date the Trust Fund Office receives the claim. This period may be extended one time by up to 15 days if the extension is necessary due to matters beyond the control of the Trust Fund Office. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Trust Fund Office expects to make a decision.

   If an extension is needed because the Trust Fund Office needs additional information from you, the Trust Fund Office will notify you as soon as possible, but no later than 30 days after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Trust Fund Office then has 15 days to make a decision on your post-service claim and notify you of the determination.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

Chapter 4

Prescription Drug Benefits

In This Chapter You'll Find:
- A Schedule of Prescription Drug Benefits
- How the Plan Works
- Mail Order Service
- Covered Drugs and Supplies
- Exclusions from Coverage
- General Plan Exclusions
- How to File a Claim

When a doctor or dentist prescribes a medicine for you or a covered dependent, your prescription drug benefits will pay 80% of the Contract Rate or 60% of Non- PPO Provider Scheduled Allowance after you have met your calendar year deductible. Your prescription drug benefits also include a mail service program for maintenance drugs (those taken on a regular or long-term basis) at a reduced cost.

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Schedule of Prescription Drug Benefits	
General Plan Features	
Calendar Year Deductible (for medical and outpatient prescription drug combined)	$250 or $350 depending on which coverage you have.
Calendar Year Limit	None
Benefits for Covered Prescription Drugs (Subject to your calendar year deductible)	
If you fill your prescription at a retail pharmacy	You pay 100% of the discounted rate at the pharmacy and send the pharmacy receipt into the Trust Fund for reimbursement. Contracted pharmacy you will receive 80% back if deductible is met and for Noncontract pharmacy you will receive 60% back once original prescription receipt is turned in.
Prescription Reimbursement *Please ask your physician if a generic drug is available instead of a brand drug. This will save you and your Fund money.	Brand drugs that have a generic equivalent will no longer be reimbursed at the applicable coinsurance (that is, 80% for Contract Pharmacies or 60% for Non-PPO Pharmacies) of the brand drug contract rate. They will be reimbursed at the applicable coinsurance of the generic drug equivalent contract. rate.
If you order your prescription through the Mail Order Pharmacy	You pay the full amount of the prescription, but you can fill a 90-day supply. Submit your prescription receipt to the Trust Fund and you will be reimbursed after your calendar year deductible has been met. Prescriptions filled at Contract Mail-Order Pharmacies are reimbursed at an 80% coinsurance, Non-PPO, Mail-Order Pharmacies at a 60% coinsurance.

How the Plan Works

The eligible participant must pay 100% of the discounted fees to the PPO Provider (pharmacy) when purchasing the prescription and 100% of the cash price to the Non-PPO Provider (pharmacy) when purchasing the prescription. The eligible participant then submits the pharmacy receipts along with the store receipt showing the amount paid, (the dollar amount on these two receipts need to match in order to get reimbursed, or we will request additional information),to the Trust Fund Office for appropriate reimbursement.

The Plan has contracted with a number of pharmacies to provide prescription drugs at discounted prices. Using one of these pharmacies works to your advantage:

- The discounted prices keep Plan costs down for everyone.
- The Plan will not cut back for utilizing discount cards that give you a larger discount than the Optum discount.

You must identify yourself as being covered through the Northern Nevada Laborers Health and Welfare Trust Fund. Take your Medical ID card with you and present it at any network pharmacy when you have a prescription filled. It is not necessary that each dependent have an ID card. Just be certain that whoever is getting a prescription filled has an ID card with him or her at that time. If there is an emergency where you find yourself in need of a prescription but without your ID card, be sure to tell the pharmacist that you are insured through the Northern Nevada Laborers Health and Welfare Trust Fund. If you need to use a Non-PPO pharmacy, you will have to pay the full cost of the prescription at the time of purchase and then submit a claim for 60% reimbursement.

Retail Pharmacies

Prescriptions filled at a retail pharmacy cannot exceed a 90-day supply.

Mail Order Service

Your prescription drug benefits include mail order service for maintenance drugs (those taken on a regular or long-term basis). You can order such drugs through OptumRx P.O. Box 509075 San Diego, CA 92510. You can contact OptumRx at 1-855-672- 3644 or www.optumrx.com. If you purchase your drugs through the mail service, you pay the discounted amounts and receive a 90-day supply. Allow up to 10 days from the day you submit your order for delivery of your medicine.

Refills

You can order refills by phone by calling toll-free at 1-855-672-3644. Make sure you have the label from the prescription you are refilling handy for reference during your call. You can also order refills by mail, using the reorder information sent with each shipment.

Covered Drugs and Supplies

Covered expenses (that require a physician prescription) include charges for the following:

- Drugs prescribed by a physician or dentist and dispensed by a licensed pharmacist.
- Insulin and insulin injection kits purchased from a licensed pharmacist.
- Drugs or insulin or insulin injection kits that are supplied to you or a covered Dependent in the physician's or dentist's office and are charged separately from any other item of expense.
- Drugs or insulin or insulin injection kits supplied by a hospital that are for use outside the hospital in connection with treatment received in the hospital, provided they are prescribed by your physician or dentist.
- Compounded dermatological preparations prescribed by a physician and dispensed by a licensed pharmacist.
- The following items when pursuant to a physician's written prescription for the treatment of a specified Illness and dispensed by a licensed pharmacist: Therapeutic vitamins, cough mixtures, antacids, and eye and ear medications.
- All FDA approved prescription contraceptives for women.
- New drugs approved by the Federal Food and Drug Administration.
- Glucose Monitors for Diabetes.

Limitation

Erectile Dysfunction Drugs will be limited to a maximum of 10 pills per month.

Exclusions from Coverage

No prescription drug benefits are provided for the following:

- Drugs that are administered while in the hospital.
- Medicines not requiring a prescription (except insulin).
- Appliances, devices, bandages, heat lamps, braces, or splints over the counter.
- Vitamins that do not require a prescription, cosmetic, dietary supplements, or health and beauty aids.
- Any filling or refilling of a prescription for drugs in excess of the supply limits mentioned above.
- Any services or supplies excluded under General Plan Exclusions, below.
- Any weight loss medication.

How to File a Claim For a Prescription Drug Benefit

To file a claim file out a medical claim form, we have this online at 169laborers.com or at the Trust Fund office, we can also mail one out to you. Submit the claim form with the prescription receipt from the pharmacy with patient name, date, drug name and the amount paid.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures.

Chapter 5
Dental Benefits

In this Chapter you'll find:
- A Quick-Reference Guide to Dental Benefits
- How the Plan works
- Maximum Benefits
- Covered Services
- Exclusions from Coverage
- General Plan Exclusions
- How to File a Claim

Your dental benefits provide coverage for services ranging from checkups and cleanings to dentures. The Plan also provides benefits for orthodontic care for you and your eligible dependents.

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may elect/decline Dental Plan benefits annually.

Option to Decline Dental Plan Coverage

In accordance with Health Reform regulations, you have the option to decline the Plan's dental coverage. To decline coverage, complete the portion of the Plan's enrollment card related to declining dental plan coverage. Enrollment cards are available from the Trust Fund Office. If you decline dental coverage you may re-enroll for such coverage after 12 months have lapsed by contacting the Trust Fund Office. Changes to the enrollment in dental plan coverage are permitted once every 12-month period.

If you choose to opt out of the dental and/or vision plan benefits, there is **no incentive, reward or financial gain** paid to you or your dependents.

If you do not elect to opt out of dental plan coverage, then you (and any eligible dependents) will automatically be enrolled in dental coverage when you enroll for medical plan coverage.

Schedule of Dental Benefits

The following Schedule of Dental Benefits is intended to provide a convenient guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

GENERAL PLAN FEATURES		
Maximum Calendar Year Benefit	$2,500 per individual aged 19 and older; no maximum for dependents 18 and younger	
Calendar Year Deductible	None	
COVERED SERVICES AND SUPPLIES		
	PPO Providers	Non-PPO Providers
Diagnostic Care:	75% of Contract Rate	75% of Scheduled Allowance
Preventive Care:	75% of Contract Rate	75% of Scheduled Allowance
Basic Services and Restorations	75% of Contract Rate	75% of Scheduled Allowance
Fixed Bridges, Partial and Complete Dentures	75% of Contract Rate	75% of Scheduled Allowance
ORTHODONTIC SERVICES		
All-Inclusive Orthodontic Care	Fund pays 50% up to maximum lifetime benefit of $1,000 ($500 max payable at initial banding)	

Covered Dental Expenses

All employees and their eligible dependents may participate in this Dental Plan pursuant to the terms outlined in Chapter 2. Dental benefits are effective on the date your medical plan benefits are effective.

Your dental benefits have been structured to provide an incentive for you to use a PPO Provider - a dentist that has contracted with the Fund to provide services at a negotiated rate. PPO Provider benefit payments are based on the contract rates, which are referred to as the Scheduled Allowance.

You are covered for expenses you incur for many, but not all, dental services and supplies provided by a Dental Care Provider that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:

- the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional dental practice and would produce a satisfactory result; **and**
- services are not **experimental or investigational; and**
- **services or supplies are not excluded** from coverage (as provided in the Dental Plan Exclusions of this document); and
- **services or supplies are not in excess** of a Maximum Calendar Year or Lifetime Plan Benefit as shown in this chapter; and
- the charges for dental services are Scheduled Allowance. See the Glossary under Scheduled Allowance.

Maximum Benefits

The Fund pays up to $2,500 in dental benefits per individual per calendar year for all participants aged 19 and over. Participants up to age 19 have no limit on the benefits they may receive.

Orthodontic care has a separate lifetime maximum benefit of $1,000 per individual (regardless of age). Orthodontic benefits are available to all eligible individuals under the Plan.

Covered Services

Subject to the dental benefit maximum(s), the Fund pays the percentages shown in the chart at the beginning of this chapter for the Covered Expenses of treatment received from a dentist or a dental hygienist working under the supervision of a dentist.

To be covered, services must be necessary, as determined by the standard of generally accepted dental practice. Expenses are deemed to be incurred on the date the service or supply is rendered.

Diagnostic and Preventive Services

Diagnostic care - procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment, including the following:

- Oral examination (2 per calendar year)
- Bitewing X-rays (2 per calendar year)
- Full mouth X-rays or panoramic x-rays, one or the other, not both (once every 36 months)
- Emergency palliative treatment
- Specialist consultation

Preventive care

- Cleanings (2 per calendar year)
- Fluoride treatment (2 per calendar year) for dependent children up to age 14
- Application of sealants on molars (once per calendar year per tooth) for dependent children up to age 14

Basic Services and Restorations

- X-rays (other than bitewing X-rays), study models, space maintainers
- Restorative-amalgam, synthetic porcelain, and plastic restorations (fillings) for treatment of carious lesions
- Endodontic treatment of the tooth pulp, including necessary X-rays and cultures
- Periodontics-treatment of gums and bones supporting teeth.

- Oral surgery-extractions and certain other surgical procedures, including pre- and post-operative care.
- Crowns, jackets, and cast restorations (replacement is covered only once every 4 years)

Major Services

- Fixed Bridges, Partial or Complete Dentures, Dental Implants. For Dental Benefits, benefits for a medically necessary dental implant will be covered up to the cost of a bridge or denture and will be subject to the maximum calendar year benefit of $2,500 applicable to all Participants older than 19 years.
- Procedures for construction or repair of fixed bridges or partial or complete dentures

Relines and rebases, including all lab or chairside treatment after 6 months of initial placement. Benefits will not be payable for the replacement of an existing prosthodontic appliance unless the existing appliance is at least four years old and cannot be made serviceable or the replacement is made necessary by the initial placement of an opposing full denture.

Orthodontic Services

The Fund provides all-inclusive orthodontic care benefits for eligible participants. The Fund pays 50% of expenses (other than those specifically excluded immediately below), with a maximum $500 payable at initial banding up to the lifetime maximum benefit of $1,000 per individual.

Orthodontic care benefits will not be paid for the following:

- Treatment plans that are unlikely to produce professionally acceptable corrections of existing malocclusion, such as (but not limited to) those for individuals with severe periodontal problems, poor bone structure, or extremely short roots.
- Orthodontic treatment that will require major restorative dental work not ordinarily performed in general dentistry.
- Replacement of lost or broken appliances or retainers

Dental Plan Exclusions

Dental benefits will not be paid for the following:

- Duplicate or replacement of a lost misplaced, or stolen orthodontic appliance, bridge, or denture before the normal prosthodontic period has passed.
- CT Cone Beam
- Expenses for preparing dental reports, bills or claim forms; mailing, shipping or handling expenses, and charges for broken/missed appointments, telephone calls, interest charges, late fees and/or photocopying fees.
- Dietary planning, oral hygiene instruction, or training in preventive dental care
- Expenses for services or supplies provided before the patient became covered under the dental program, including prosthodontic services or any single procedure started before you and your dependents became eligible for such services under this Plan, for example, teeth extracted prior to the date you were eligible for coverage, except coverage may still be available when the denture or fixed bridgework also includes replacement of a natural tooth that is extracted while you are covered and the appliance is not an abutment to a partial denture or fixed bridgework installed within the preceding 4 years
- Expenses for services rendered or supplies provided after the date the patient's coverage ends, with the exception that prosthodontic appliances, crowns, or bridges that were ordered while you or a covered dependent were eligible but are installed or delivered within 60 days after termination of eligibility may still be covered, and except under the COBRA provisions of the Plan.
- Expenses for services rendered or supplies provided that were not recommended or prescribed by a Dentist.
- Expenses for dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for fluoride treatments).
- All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law. This applies even if you or your covered Dependent were not covered by workers' compensation insurance, or if the Covered Individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.
- Services performed by the spouse, child, sibling (by birth or marriage, such as a brother-in-law), aunt/uncle, or parent of the patient or covered Plan participant.

- Expenses for any dental services, supplies, drugs, or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Glossary.
- Services for congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons as determined by the Plan Administrator or its designee, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth), bleaching/whitening of teeth, and veneers.
- Expenses for any dental services or appliances to increase vertical dimension, restore occlusion, stabilize tooth structure lost by wear or bruxism (clenching/grinding of teeth) and devices for harmful habits such as thumb-sucking (except as provided as part of a payable course of Orthodontia treatment as outlined in the Dental Benefits, above).
- Prescribed drugs, pre-medication, including analgesia, sedation, or hypnosis and/or other related services provided for apprehension or anxiety when not included in the charge for covered dental services.
- All hospital costs and any additional fees charged by the dentist for hospital treatment (except as payable under the Medical Plan as noted in the Medical Benefits Chapter).
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services.
- Charges for general anesthesia and the outpatient surgical facility for children under the age of 6 that require services outpatient, see the Medical Benefit page 32 for limited covered services.
- Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party.
- Any services or treatments excluded under "Covered Services" above.
- Any services or treatments excluded under General Plan Exclusions, below.

The Plan Administrator, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Dental Plan has been delegated, will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

How to File a Claim for Dental Benefits

For information on how to file a claim for Medical Benefits, including Dental Benefits, please refer to the subsection entitled How to File a Claim for Medical Benefits in Chapter 3, above.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

Chapter 6

Vision Care Benefits

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may elect/decline Vision Plan benefits annually

In this Chapter you'll find:

- A Schedule of vision care benefits
- How the Plan works
- Covered services and materials
- Exclusions from coverage
- General Plan Exclusions
- How to File a Claim

Option to Decline Vision Plan Coverage

In accordance with Health Reform regulations, you have the option to decline the Plan's vision coverage. To decline coverage, complete the portion of the Plan's enrollment card related to declining vision plan coverage. Enrollment cards are available from the Trust Fund Office. If you decline vision coverage you may re-enroll for such coverage after 12 months have lapsed by contacting the Trust Fund Office. Changes to the enrollment in vision plan coverage are permitted once every 12-month period.

If you choose to opt out of the vision plan benefits, there is **no incentive, reward or financial gain** paid to you or your dependents.

If you do not elect to opt out of vision plan coverage, then you (and any eligible dependents) will automatically be enrolled in vision coverage when you enroll for medical plan coverage.

Schedule of Vision Benefits

Your vision care benefits provide you and your covered dependents with reimbursement allowances for eye exams and corrective eyewear.

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Item	PPO Provider	Reimbursement Allowance for Non-PPO Provider (annual maximums do not apply to dependents under age 19)
Exam	100% of the Contract Rate	Up to $40
Frames	100% of the Contract Rate on Select Frames	Up to $35
Eyeglass Lenses		*(All reimbursements are per pair)*
• Single Vision	100% of Contract Rate	Up to $36
• Bifocal	100% of Contract Rate	Up to $55
• Trifocal	100% of Contract Rate	Up to $70
• Lenticular	100% of Contract Rate	Up to $150
Tints and Coatings		
• Photogrey tint or UV coating (employee only)	100% of Contract Rate	Up to $20
• Tint, Rose #1 or #2 (dependents)	100% of Contract Rate	Up to $7
Contact Lenses (instead of glasses)		
• Medically Necessary	100% of Contract Rate	Up to $225 per pair
• For Cosmetic Purposes	100% of Contract Rate	Up to $96 per pair

How the Plan Works

Your vision benefits have been structured to provide an incentive for you to use a PPO Provider-an optometrist, ophthalmologist, or optician - that has contracted with the Fund to provide services at negotiated rates. Benefit payments are based on the contract rates. If you choose to upgrade or otherwise depart from what the Plan covers, you will be responsible for any costs in excess of what the Plan covers. Some PPO Providers will give a discount on upgrades (you will need to make arrangements for the discount at the time of your visit).

If you use a Non-PPO Provider, benefit payments are based on Scheduled Allowance for Covered Expenses. Non-PPO providers are under no obligation to limit their costs to the Scheduled Allowances. This schedule is amended from time to time. If you have a question about the allowable amount for a specific service, you can call the Trust Fund Office.

Covered Services and Materials

Reimbursements for an eye examination (refraction), a frame and a pair of lenses are available once per calendar year.

Contact lenses may be substituted instead of glasses. Contact lenses are considered medically necessary under the following conditions:

- following cataract surgery,
- to correct extreme visual acuity problems that cannot be corrected with spectacle lenses,
- in cases of keratoconus (conical protrusion of the cornea).

In all other cases, contact lenses are considered to be for cosmetic purposes.

Exclusions from Coverage

The Fund will not pay benefits for the following:

- Replacement of lenses and frames that are lost or broken (except at the normal intervals when services are otherwise available)
- Orthoptic or vision training, non-prescription lenses, glasses secured when replacement is not deemed medically necessary, or a second pair of glasses in lieu of bifocals.
- Non-prescription sunglasses
- Medical or surgical treatment of the eyes
- Services or materials provided because of any Workers' Compensation law or similar legislation or services that can be obtained without cost from any Federal, state, county, or local organization or agency.
- Any eye examination or glasses required by an employer or any service or materials provided by any other vision care plan or group benefit plan containing benefits for vision care.
- Any services or treatments excluded under General Plan Exclusions, below.

How to File a Claim for Vision Care Benefits

For information on how to file a claim for Medical Benefits, including Vision Care Benefits, please refer to the subsection entitled How to File a Claim for Medical Benefits in Chapter 3, above.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

In this chapter you'll find:
- How the Plan Works
- Repeated Instances of Disability
- Exclusions from Coverage
- General Plan Exclusions
- How to File a Claim

Chapter 7
Weekly Disability Benefits Coverage (Active Employees Only)

Weekly Disability Benefits	Help replace lost income when you are disabled, paying $250 per week for up to 13 weeks. Benefits begin the first day for a disability caused by an accidental injury or on the 8th day for a disability caused by illness.

How the Plan Works

The Fund will pay you a weekly benefit of $250 (minus FICA) for up to 13 weeks if you become totally disabled and unable to work while you are eligible for benefits under this Plan.

Definition of "Totally Disabled"

For purposes of this benefit, "totally disabled" means you are unable, due to illness, injury, or pregnancy, to perform substantially all of the material duties of the occupation in which you were engaged when you became so disabled and that you are not engaged in any gainful occupation.

A physician's certification of total disability is required.

Start and Duration of Benefits

Weekly disability benefits begin as follows:

- on the first day of a disability resulting from an injury
- on the eighth day of a disability resulting from an illness

Benefits will continue until you are no longer disabled, or you have reached the maximum of 13 weeks of continuous payments. NOTE: Weekly disability benefits are subject to Federal income tax and Social Security/Medicare taxes.

Repeated Instances of Disability

There is no limit to the number of times you may receive weekly disability benefits, provided your periods of disability meet the Plan's rules for having separate periods of disability. To be considered separate, your periods of disability must be:

- due to unrelated causes and/or separated by a return to active full-time employment; or
- if due to a related cause and separated by at least one day of full-time employment or availability for work certified by a Physician.

Exclusions from Coverage

No benefits are payable for the following disabilities:

- A disability that began before you became eligible for benefits under the Fund.
- Any illness or injury arising out of or in the course of employment.
- Any bodily illness or injury for which evidence is not furnished to the Fund that you are totally disabled.
- Any disability suffered by your spouse or dependent children (weekly disability benefits cover employees only)

No benefits are payable under the following circumstances:

- Once you are receiving Social Security benefits
- Once you are receiving pension benefits

Extension of Benefits for Total Disability

If the participant is Totally Disabled and under the care of a Physician at the time coverage ends due to loss of eligibility, Comprehensive Medical Benefits shall be extended for Covered Expenses incurred after the date of termination. These extended benefits are subject to the same terms that would have applied if the Plan had remained in force. These extended benefits are payable only for Covered Expenses incurred:

- For treatment of the specific illness or injury that caused Total Disability:
- While the participant remains Totally Disabled:
- During the first twelve consecutive months after the date of termination.

Extended benefits are provided until the first of the following occurs:

- The Participant is no longer Totally Disabled; or
- A period of twelve consecutive months has passed since the date of termination; or
- The Participant becomes covered under any plan providing similar coverage.

Written certification must be submitted by the Physician that the Participant is Totally Disabled. The Fund must receive this certification within 90 days of the date of termination. At least once every 90 days while benefits are extended, The Fund must receive proof that the Participant continues to be Totally Disabled

How to File a Claim for Weekly Disability Benefits

To file a claim for weekly disability benefits, follow these steps:

- Obtain a Statement of Claim for Accident and Sickness Weekly Benefits from the Trust Fund Office.
- Complete the active employee's portion of the claim form.
- Have your physician complete the attending physician's portion of the claim form.
- Check the claim form to be certain that all applicable portions of the form are completed. By doing so, you will speed the processing of your claim.

Mail your claim form to the Northern Nevada Laborers Health and Welfare Trust Fund P.O. Box 11337 Reno Nevada 89510.

If the Fund needs additional information from you to make its decision, you will be notified as to what information must be submitted.

If you disagree with the decision made on your claim, you may appeal the decision. See Chapter 13: Claims Appeal Procedures for more information.

If you have any questions about submitting your claim, contact the Trust Fund Office.

When Claims Must Be Filed

All claims should be filed within 90 days following the first day of a disability resulting from an injury or the eighth day of a disability resulting from an illness. The claim must be received within one (1) year from the first day of a disability resulting from an injury or the eighth day of a disability resulting from an illness.

Timing of Initial Weekly Disability Claim Decision

The Trust Fund Office will ordinarily make a decision on the claim and notify you of the decision within 45 days of receipt of the claim. This period may be extended by up to 30 days if the extension is necessary due to matters beyond

the control of the Trust Fund Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date as of which the Trust Fund Office expects to make a decision. A decision will then be made within 30 days of when the Trust Fund Office notifies you of the delay. The period for making a decision may be extended an additional 30 days, provided the Trust Fund Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Trust Fund Office expects to render a decision.

If an extension is needed because the Trust Fund Office needs additional information from you, the Trust Fund Office will notify you as soon as possible, but no later than 45 days after receipt of the claim, of the specific information necessary to complete the claim. You will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). Once you respond to the Trust Fund Office's request for the information, you will be notified of the Trust Fund Office's decision on the claim within 30 days.

For disability claims, the Fund reserves the right to have a physician examine you (at the Fund's expense) as often as is reasonable while a claim for benefits is pending.

Maximum Times for Processing of Disability Claims ***(Times are suspended while the Trust Fund Office is waiting for additional information It has requested of you)***	
Trust Fund Office or Insurance company makes Initial determination (provided all necessary information is submitted)	Within 45 days of claim's receipt (can be extended for another 30 days and an additional 30 days after that)
Trust Fund Office requests additional information	Within 45 days of claim's receipt
You furnish requested Information	Within 45 days of request
Trust Fund Office makes determination after requesting information	Within 30 days of receipt of information or expiration of time allowed

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

Chapter 8

Employee Life Insurance

In This Chapter You'll Find:
- How the Plan Works
- Extended Coverage for Disability
- General Plan Exclusions
- How to File a Claim

Unlike the benefits discussed in the preceding chapters, which are paid directly by the Fund, employee life insurance is provided through an insurance contract with The Union Labor Life Insurance Company (ULLICO). This coverage is governed by the terms of that policy. If there is any conflict between the terms of this document and the terms of the Insurer's policy, the Insurer's policy controls.

Employee Life Insurance	Plasterers	$25,000
	Cement Masons	$25,000
	Flat Raters	$25,000
	Brick Hod Carriers	$10,000
	Plaster Hod Carriers	$10,000
	Laborers	$10,000
	Retirees	$1,000

How the Plan Works

This Plan pays a $1,000, $10,000 or $25,000 benefit in the event of your death from any cause while you are insured under the Plan.

Payment of the Benefit

The Specific Dollar benefit will be paid to your beneficiary as filed with the Trust Fund Office.

Your Beneficiary

Your beneficiary is the person, or one of the persons, you designate to receive any benefit payable for the loss of your life. You may designate anyone as your beneficiary by completing an Enrollment Card and returning it to the Trust Fund Office. You may change your beneficiary designation at any time. The consent of a beneficiary is not required.

If there are two or more beneficiaries, the benefits will be paid in equal shares unless you state otherwise. If a beneficiary does not live to receive payment, that share will pass equally to the remaining beneficiaries, unless you state otherwise.

If you have not named a beneficiary or if your beneficiary does not live to receive the payment, benefits will be paid to the first of the following living family members:

- your spouse,
- your natural and adopted children, in equal shares.
- your parents, in equal shares, or
- your brothers and sisters in equal shares.

If none of these lives to receive payment, the benefit will be paid to your estate.

If your beneficiary is a minor or someone not able to give a valid release for payment, the Claims Administrator will pay the benefit to his or her legal guardian. If there is no legal guardian, the Claims Administrator may pay the individual or institution who has, in his opinion, custody and principal support of such a Beneficiary.

Life Insurance During Total Disability (Active Employees Only)

If you become totally disabled while you are under age 60, the Life Insurance Benefit will continue without premium payments if the disability has existed uninterruptedly for 9 months, and the employee has not converted their Life Insurance Benefit. For purposes of this extended benefit, "totally disabled" means that you are unable, due to illness or injury, to work in any business, occupation, or employment.

The Life Insurance Benefit provisions state that the necessary forms and written proof of total disability must be submitted to the Union Labor Life Insurance Company after you have been disabled for 9 months but within 1 year from the date the Employee.

first became disabled. You will be required to submit evidence of your continuing total disability during each successive one year of your disability.

Total Disability Extension

To file for an extension, follow these steps:

- Obtain a Disability Extension Application from the Trust Fund Office.
- Complete the active employee's portion of the claim form.
- Have your physician complete the attending physician's portion of the claim form.
- Check the claim form to be certain that all applicable portions of the form are completed. By doing so, you will speed the processing of your claim.
- Mail your claim form to:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, Nevada 89510.

Employees' Life Insurance Benefit Conversion Privilege

If You Cease to be Eligible for Life Insurance

If your coverage under this group life insurance plan ends because you cease to be eligible, you may convert to an individual policy with no evidence of insurability, provided you apply in writing and pay the first premium within 31 days after coverage under the life insurance benefit ends.

You may choose any type of individual contract being written by The Union Labor Life Insurance Company, except term insurance or insurance that provides disability or other supplementary benefits. The benefit amount of converted insurance may not exceed the benefit amount under this policy.

Conversion Option Under Other Circumstances

You will also be able to convert as explained above if you have been continuously covered for at least 5 years and

- the group insurance policy terminates,
- the life insurance benefit terminates for the class of employees you are in, or
- your employer stops being a covered employer.

In such a case, the benefit amount cannot exceed the lesser of

- the benefit amount available on the date of termination, less any life insurance for which you are eligible or become eligible under any group policy within the conversion period or
- $2,000.

Applying for Conversion

If you wish to take advantage of the conversion option, contact the Trust Fund Office within 16 days of the date the policy terminated. The first premium is due within 31 days from the date the policy terminated.

NOTE: If you die during the 31-day period allowed for conversion, Union Labor Life Insurance Company will pay the life insurance benefit you could have converted to the last beneficiary you named, whether you have applied for conversion or paid the first premium.

How to File a Claim for Employee Life Insurance Benefits

Your beneficiary should notify the Trust Fund Office and the Union Labor Life Insurance Company as soon as possible after your death. The Trust Fund Office will then send your beneficiary the forms necessary for filing proof of the loss and a claim for the benefit.

Your beneficiary should complete the claim form and attach ***a certified original copy of the death certificate***.

The claim form should be mailed to:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, Nevada 89510.

When Claims Must Be Filed

Your beneficiary must file a claim for benefits within 90 days of the loss. More time may be allowed if your beneficiary cannot reasonably file the claim and proof of loss within this time, but in any event the claim must be received within one (1) year of the date of the loss.

Timing on Initial Life Insurance Claim Decision

The insurance company will ordinarily make a decision on a claim for life insurance within 90 days of receipt of the claim. This period may be extended by up to 90 days if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date as of which the insurance company expects to make a decision.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

Chapter 9

Life Insurance for Dependents of Active Employees

In This Chapter You'll Find:
- How the Plan Works
- Conversion Option
- General Plan Exclusions
- How to File a Claim

Like employee life insurance, life insurance for your eligible dependents is provided. through an insurance contract with The Union Labor Life Insurance Company (ULLICO). If there is any conflict between the terms of this document and the terms of the Insurer's policy, the Insurer's policy controls.

Dependent Life Insurance Benefits	
Death of Your Spouse	$2,000
Death of Your Dependent Child	$1,000

*See Chapter 2 for information on extended eligibility for disabled children unable to support themselves.

How the Plan Works

The Plan will pay you, the employee, a life insurance benefit if one of your eligible dependents dies. If you are no longer living, it will pay the benefit to the estate of your deceased dependent.

Benefit amount is shown in the chart above.

Conversion Option

If life insurance for your dependents terminates because you cease to be eligible for employee life insurance or the dependents cease to be eligible dependents, they can convert their coverage to individual policies with no evidence of insurability.

They may choose any type of individual contract being written by ULLICO, except term insurance or insurance that provides disability or other supplementary benefits.

To exercise this conversion option, a dependent must apply in writing and pay the first premium within 31 days after coverage ends. The benefit amount of converted insurance may not exceed the benefit amount under this policy.

Conversion Option Under Other Circumstances

Dependents will also be able to convert as explained above if they have been continuously covered for at least 5 years and

- the group insurance policy terminates or
- the life insurance benefit terminates for the class of dependents the dependent is in.

In such a case, the benefit amount cannot exceed the lesser of

- the benefit amount available on the date of termination, less any life insurance for which the dependent is eligible or becomes eligible under any group policy within the conversion period or
- $2,000.

Applying for Conversion

If a dependent wishes to take advantage of the conversion option, the dependent can contact the Trust Fund Office within 16 days of the date the policy terminated. The premium is due within 31 days from the date the policy terminated.

NOTE: If your dependent dies during the 31-day period allowed for conversion, ULLICO will pay the life insurance benefit he or she could have converted, whether or not the dependent has applied for conversion or paid the first premium.

How to File a Claim for Dependent Life Insurance Benefits

You should notify the Trust Fund Office and the Union Labor Life Insurance Company as soon as possible after your dependent's death.

The Trust Fund Office will then send you the forms necessary for filing proof of the loss and a claim for the benefit. You may also request the forms from the Union Labor Life Insurance Company.

Complete the claim form and attach a certified original copy of the death certificate. Mail the claim form to:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, Nevada 89510.

When Claims Must Be Filed

You must file a claim for benefits within 90 days of the loss. More time may be allowed if you cannot reasonably file the claim and proof of loss within this time, but in any event the claim must be received within one (1) year of the date of the loss.

Timing on Initial Life Insurance Claim Decision

The insurance company will ordinarily make a decision on a claim for life insurance within 90 days of receipt of the claim. This period may be extended by up to 90 days if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date as of which the insurance company expects to make a decision.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures. For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started”.

Chapter 10

Employee Accidental Death and Dismemberment (AD&D) Insurance

In This Chapter You'll Find
- Schedule of Employee AD&D Benefits
- How the Plan Works
- Exclusions from Coverage
- General Plan Exclusions
- How to File a Claim

Like employee and dependent life insurance, employee AD&D insurance is provided through an insurance contract with The Union Labor Life Insurance Company (ULLICO). AD&D coverage is not provided for dependents. If there is any conflict between the terms of this document and the terms of the Insurer's policy, the Insurer's policy controls.

Schedule of Employee AD&D Benefits	
Description of Loss	**Benefit Payable**
Your death	$10,000 OR $25,000
Loss of both hands or both feet	$10,000 OR $25,000
Loss of sight in both eyes	$10,000 OR $25,000
Loss of one hand and one foot	$10,000 OR $25,000
Loss of one hand (or one foot) and sight in one eye	$10,000 OR $25,000
One-Half Benefit Payable For	
Loss of one hand or one foot	$5,000 OR $12,500
Loss of sight in one eye	$5,000 OR$12,500

Loss of a hand or foot means the complete and permanent severance of the entire hand or foot at or above the wrist or ankle joint. Loss of sight in an eye means the entire and permanent loss of the sight of that eye. If you suffer more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

How the Plan Works

The Plan insures you for up to $10,000 or $25,000 against death or dismemberment in an accident. The amount payable depends on the nature of the loss, as shown in the chart above. Flat Raters, Plasterers, and Cement Masons have the $25,000 benefit and all other Participants have the $10,000 benefit.

The loss must be the direct result of a bodily injury suffered in a covered accident (on or off the job) and must occur at the time of the accident or within 90 days of the accident, independently of all other causes. The injury causing the loss must be sustained while you are insured under the Plan. If you suffer more than one loss in a single accident, the maximum combined benefit for all losses will be $10,000 or $25,000.

If the loss is your death, the $10,000 or $25,000 benefit will be paid to your beneficiary. You will find more information about beneficiaries in the Employee Life Insurance section of this SPD. This is in addition to the $10,000 or $25,000 employee life insurance benefit.

The benefit for any other AD&D loss will be paid to you, the employee.

Exclusions from Coverage

No AD&D benefit is paid for a loss caused or contributed to by any of the following:

- Suicide or attempted suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness or disease of any kind.
- Medical or surgical treatment of an illness or disease.
- Bacterial infection or bacterial poisoning (Exception: Infection from a cut or wound caused by an accident).
- War or act of war declared or undeclared; or any act related to war, or insurrection.

- Service in the armed forces of any country while such country is engaged in war.
- Participation in, or the result of participation in, the commission of an assault, or a felony, or a riot, or a civil commotion or.
- Intake of any drug, medication or sedative unless prescribed by a Doctor, or the intake of any alcohol in combination with any drug, medication or sedative.

Accidental Death Claims

Your beneficiary should notify the Trust Fund Office and the Union Labor Life Insurance Company as soon as possible after your death.

The Trust Fund Office will then send your beneficiary the forms necessary for filing proof of the loss. You may also request the forms from the Union Labor Life Insurance Company. Your beneficiary should complete the claim form and attach a certified original copy of the death certificate. An autopsy report and police report are required.

The claim form should be mailed to:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, Nevada 89510

Dismemberment and Loss of Sight Claims

Notify the Trust Fund Office and the Union Labor Life Insurance Company as soon as possible if you suffer one of the losses due to an accident. The Trust Fund Office will then send you the form necessary for filing proof of the loss. You may also request the forms from the Union Labor Life Insurance Company.

Complete the claim form. Have your physician complete the physician's portion of the form.

The claim form should be mailed to:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, Nevada 89510

When Claims Must Be Filed

You or your beneficiary must file a claim for benefits within 90 days of the loss. More time may be allowed if you or your beneficiary cannot reasonably file the claim and proof of loss within this time, but in any event, the claim must be received within one (1) year of the date of the loss.

Timing on Initial AD&D Claim Decision

The insurance company will ordinarily make a decision on a claim for AD&D insurance within 90 days of receipt of the claim. This period may be extended by up to 90 days if the extension is necessary due to matters beyond the control of the insurance company. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date as of which the insurance company expects to make a decision.

Important Claims Information

For information on what to do if you disagree with the decision made in regard to your claim, see Chapter 13: Claims Appeal Procedures For information on limitations on when you may start a lawsuit to obtain benefits see “Limitation on When a Lawsuit May Be Started” beginning on page 70.

Chapter 11

Coordination of Benefits (COB)

In This Chapter You'll Find
- Coordination with Group Health Plans
- Coordination with Individual Plans
- Coordination with Individual Plans

An individual plan (that is, a non-group plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, group practice, individual practice plan, or through the Health Insurance Marketplace, pays first; and this Plan pays second.
- Coordination with Prepaid Plans
- Coordination with Medicaid
- Coordination with Medicare
- Coordination with COBRA

Coordination of Health Care Benefits

The health care benefits provided by the Fund are "coordinated" with any benefits under any other group plan or government plan that covers you or your dependents.

Coordination of benefits means that one plan pays benefits first (the primary payer) and one pays second (the secondary payer), with the combined total of benefits not to exceed the maximum Covered Expenses.

Coordination with Group Health Plans

If the Fund is the primary payer, it pays its benefits to you first, without regard to any other plan. If the Fund is the secondary payer, it will pay the amount of covered charges not covered by the primary plan (subject to deductible, coinsurance, benefit and lifetime maximums, and other provisions described in this booklet). In any case, the benefit paid will not exceed the allowance in the applicable schedule of allowances or the contracted fee, whichever is lower.

Primary and secondary payers are as follows (NOTE: Coordination with prepaid plans, Medicaid, and Medicare have different provisions, which are explained later below):

- **Employees:** This plan may cover an active employee or retired employee as either primary or secondary based on applicable laws and regulations. A Secondary plan covering you as a laid-off or retired employee (This order will extend to any dependent coverage you have under the plans, too.)

  NOTE: If you are an employee covered under one or more of the funds signatories to the Reciprocity Agreement described in Chapter 2 of this booklet and you are available for work but ineligible for coverage under one or more of the funds, responsibility for your coverage will be determined in accordance with the administrative procedures outlined in the Reciprocity Agreement.

- **Spouses:** The plan covering the spouse directly, as a non-dependent rather than as an employee's dependent, is the primary plan. The plan covering the spouse as a dependent is the secondary plan.

- **Children:** If the child is covered as a dependent by more than one plan, and if the parents are not separated or divorced, the primary plan is the plan of the parent whose birthday falls earlier in the calendar year. If the other plan does not have this "birthday rule," the rules in the other plan will determine the order of benefits.

  If the parents are separated or divorced and two or more plans cover a child as a dependent, benefit payments are first determined in accordance with any court decree. The primary plan is the first of the following that exist, and the other plan(s) are secondary:

  — The plan of the parent with custody

  — The plan of the stepparent which is the spouse of the parent with custody

  — The plan of the parent without custody pays last, unless stated different in court decree.

  — If none of the rules outlined here apply, the plan that has covered the dependent child for a longer period will pay first.

Coordination with Individual Plans

An individual plan (that is, a non-group plan purchased by an individual), whether provided through a policy, subscriber contract, health care network plan, group practice, individual practice plan, or through the Health Insurance Marketplace, pays first; and this Plan pays second.

Coordination with Prepaid Plans

If you and your dependents are also covered by a prepaid plan (an HMO, individual practice association, or similar program), the prepaid plan's benefits are typically available only if you use that plan's providers. Choosing how you receive services from the prepaid plan's providers or from other providers determines which plan is responsible for benefits. If you use the prepaid plan's providers, benefits payable by the Fund will be limited to reimbursement of the standard co-payment you are required to make when you use the prepaid plan's providers. The Fund will not pay expenses for services covered by the prepaid plan. This will be true regardless of which plan would otherwise be primary.

Coordination with Medicaid

If an individual is covered by both this Plan and Medicaid or a State Children's Health Insurance Program (CHIP), this Plan pays first, and Medicaid or the State Children's Health Insurance Program (CHIP) pays second. Payments by this Plan will be made in compliance with any assignment of rights as required by Nevada's plan for medical assistance approved under Title XIX, Section 1912(a)(I)(A) of the Social Security Act (Medicaid).

If the state has paid for medical assistance under Medicaid in any case where this Plan has a legal liability to make payment for such assistance, payment for the benefits will be made in accordance with any state law giving the state rights to such payment with respect to an eligible individual.

Coordination with Medicare

This plan is secondary to Medicare for Medicare eligible employees except where applicable laws and regulations mandate otherwise.

If an individual eligible for benefits under the Plan is covered by Medicare, that individual will be considered to have full Medicare coverage (Parts A and B), whether or not he or she is enrolled for all parts of Medicare.

Any Plan exclusions for services furnished under a government program will not apply to services provided under Medicare. Medicare is considered a "group plan" for the purposes of coordination of benefits.

Unless otherwise mandated by law, the Plan will never be primary for retired Medicare eligible participants.

Age-Related Eligibility for Medicare

If you are an active employee (which includes continued eligibility for the Fund's group health plan due to accumulation of an hour bank), your coverage under this Plan will not change when you become entitled to Medicare. However, when you become eligible for Medicare as an active employee, this Plan will be primary, and Medicare will assume secondary payer coverage. When active employee status is lost (including when your hour bank is exhausted), Medicare will become primary, and this Plan will become secondary.

End-Stage Renal Disease

If you or any of your covered dependents becomes eligible for Medicare on the basis of end-stage renal disease (ESRD) while you are an active employee, benefits for the individual with ESRD will be coordinated with Medicare for 30 months.

Medicare will be secondary for 30 months; after that, Medicare will be primary. These 30 months begin the earlier of:

- the month in which Medicare ESRD coverage begins or
- in the case of an individual who receives a kidney transplant, the first month in which he would be eligible for ESRD benefits.

Beginning with the 31st month (or the 34th month, in the case of a transplant patient), Medicare will become the first payer whether or not the individual is still entitled to coverage under this Plan.

Disability Cases

If you become entitled to Medicare as a result of a disability, Medicare will be the secondary payer while you are covered as an active employee.

If a covered dependent becomes entitled to Medicare as a result of a disability, Medicare will be the secondary payer, and the Plan will be the primary payer.

Coordination with COBRA

In situations involving coordination of benefits where one source of benefits is COBRA under this plan or another plan, this plan is secondary except where applicable laws and regulations mandate otherwise.

Coordination with TRICARE

This plan is primary for active employees and dependents and TRICARE is secondary. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary, and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

Coordination with Indian Health Services (IHS)

This plan is primary for active employees and dependents and Indian Health Services is secondary.

Coordination with Veterans Administration (VA)

If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan to the extent those services are Medically Necessary and the charges are Allowed Charges.

Coordination with Auto Insurance

This plan will coordinate with auto insurance, subject to the plan's subrogation reimbursement provisions, with auto insurance being primary and this plan being secondary. The amount paid by auto insurance must be obtained prior to payment of any expenses related to the accident. Correspondence from the automobile insurance carrier should specifically state all benefits under the automobile insurance coverage have been exhausted. This information is necessary to properly calculate the secondary benefit.

Coordination with Homeowners Insurance

This plan will coordinate with homeowners' insurance, subject to the plan's subrogation reimbursement provisions, with homeowners' insurance being primary and this plan being secondary. The amount paid by homeowners' insurance must be obtained prior to payment of any expenses related to the accident. Correspondence from the homeowners' insurance carrier should specifically state all benefits under the homeowners' insurance coverage have been exhausted. This information is necessary to properly calculate the secondary benefit.

If You Have Other Insurance

It is your responsibility to notify the Trust Fund Office if you have other insurance.

The other insurance inquiry form (which members are required to complete, sign, and submit to the Trust Fund Office at least once each calendar year) asks you whether you have other insurance. By entering the requested information on the form, you take care of your notification responsibility. If you do not respond to the form, it will result in claims being denied. You can find this form on 169laborers.com or at the Trust Fund office.

Chapter 12

COBRA Temporary Continuation of Health Care Coverage

In This Chapter You'll Find

This section serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to all employees and is intended to inform them (and their covered dependents, if any) in a summary fashion of their rights and obligations under the continuation provisions of the federal law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called COBRA), eligible employees, eligible retirees and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law).

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan, see your state Health Insurance Marketplace or www.healthcare.gov).

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), if you request enrollment in that other plan within 30 days of losing coverage under this Plan, even if that other plan generally does not accept late enrollees.

COBRA Administrator

The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is:

Northern Nevada Laborers Health and Welfare Trust Fund
Trust Fund Office
445 Apple Street
P.O. Box 11337
Reno, NV 89510
Phone: (775) 826-7200
Toll Free: (877) 826-5053
Fax: (775) 824-5080

Qualified Beneficiary

Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage when a Qualifying Event occurs, and as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered employees and retirees may elect COBRA on behalf of their spouses and covered parents/legal guardians may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other covered individuals including Special Enrollment.

Under the law, a Qualified Beneficiary is any Employee or Retiree, or the Spouse or Dependent Child of an employee or retiree, who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary.

- A child of the covered employee or retiree who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the employee's period of employment, is entitled to the same rights under COBRA as an eligible dependent child.

- A person who becomes the new Spouse of an existing COBRA participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA participant but is not a "Qualified Beneficiary." This means that if the existing COBRA participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

Qualifying Events

If one of the following events (known as a Qualifying Event) occurs and results in a loss of coverage, you and your eligible Dependents have the right to continue health coverage that was in effect at the time of the Qualifying Event under a federal law known as COBRA. COBRA Continuation Coverage is available through the Northern Nevada Laborers Health and Welfare Trust Fund for those who qualify. To receive this continuation coverage, you must pay monthly premiums to the Fund. (See COBRA Continuation Coverage Reference Chart on page 68) The following are Qualifying Events:

1. Reduction of work hours or reduction to less than the minimum required (100) hours in your hour bank (hours previously banked plus hours reported by your Employer)
2. Termination of your employment (for reasons other than gross misconduct)
3. Your divorce
4. Your death
5. The loss of status as a Dependent child

Duration of COBRA

COBRA coverage can continue for up to 18, 29 or 36 months, depending on the COBRA Qualifying Event

- **18 Months** - You and/or your Dependents can continue coverage for up to 18 months from the date of the Qualifying Event if you would otherwise lose coverage because less than the minimum work hours were reported for a month on your behalf.
- **29 Months** - An 18-month coverage period can be extended to a total of 29 months if you or your Dependent becomes disabled (as determined by the Social Security Administration) before or during the first 60 days of COBRA coverage, See "Extended COBRA Coverage in Cases of Disability."
- **36 Months** - Each of the other above-listed Qualifying Events (Items 2 through 4) entitles your Dependents to 36 months of coverage from the date of the Qualifying Event. (In the case of a child losing Dependent status, only the affected child is eligible for 36 months of coverage.)

Extended COBRA Coverage in Cases of Disability

If you and/or your Dependents are entitled to COBRA coverage for an 18-month period, that period can be extended for an eligible person who is determined to be entitled to Social Security Disability Income benefits, and for any other eligible family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage or within the first 60 days of COBRA coverage.
- The disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.
- The disabled person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The employee, the disabled person or other agent or authorized representative notifies the Trust Fund Office that the determination was received. See "Your Duty to Notify the Trust Fund Office" below for notification deadlines.

The premium for the additional months will be approximately 50% higher than the premium for the initial 18 months of COBRA coverage.

Extended COBRA Coverage if a Second Qualifying Event Occurs

If, during an 18-month period of COBRA Continuation Coverage resulting from insufficient work hours, the Employee dies, divorces, or if a covered child ceases to be a Dependent child under the Plan, the maximum COBRA coverage period for the affected spouse and/or child is extended to 36 months from the date of the first Qualifying Event.

If you marry after the first Qualifying Event, this extended period of COBRA coverage is not available to your new spouse. However, this extended period of COBRA coverage is available to any children born to, adopted by, or placed for adoption with the employee during the 18-month period of COBRA coverage. See "Your Duty to Notify Trust Fund Office" below regarding your responsibility to notify the Trust Fund Office that a second qualifying event has occurred.

Effect of Medicare Entitlement Before a Termination of Employment or Reduction in Hours

If you are an employee and the insufficient work hours (including your hours banked) occurs less than 18 months after the date you became entitled to Medicare (Part A, Part B or both), the maximum period of continuation coverage for your Dependents will be 36 months after the date of your Medicare entitlement.

Note: Medicare entitlement is not a qualifying event under this plan. Medicare entitlement after a termination of employment or the reporting of insufficient work hours will not extend a Dependent Qualified Beneficiary's COBRA coverage beyond the 18- month coverage period.

Cost of Continuation Coverage - Benefits That May Be Continued

COBRA Continuation Coverage is available only at your own expense. If you or your Dependents elect to continue coverage, the full cost, plus a 2% administrative charge, will be charged (in the case of an extension due to disability, it is the full cost plus 50%). You may elect to continue medical and prescription drug coverage only (Core Coverage) or medical, prescription drug, vision and dental coverage (Core Plus Coverage). Dental and vision coverages do not have to be continued; however, you may not continue one of these benefits without the other. COBRA coverage does not include life insurance, AD&D or weekly disability coverage.

Paying for COBRA Coverage

The Trust Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

There will be an initial grace period of 45 days to pay the first premium due starting with the date COBRA coverage was elected. If this first payment is not made when due, COBRA coverage will not take effect. After the first payment, subsequent payments are due each month. There will be a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate.

If you make a payment later than the first day of the coverage month to which it applies, but before the end of the grace period for that month, your benefits under the plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

For Monthly Payments, What If the Full COBRA Premium Payment Is Not Made When Due?

If the Trust Fund Office receives a COBRA premium payment that is not for the full amount due, the Trust Fund Office will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be significantly short of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Trust Fund Office will notify the Qualified Beneficiary of the deficiency amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

How to Obtain COBRA Continuation Coverage

The Trust Fund Office will determine when you do not have sufficient hours in your hour bank. In the event of your death, the Trust Fund Office will notify your dependents of their COBRA rights when it becomes aware of the death through notification from an employer, a union officer, in the course of administering the Plan's benefits, or otherwise.

Your Duty to Notify the Trust Fund Office

You or your dependents are responsible for providing the Trust Fund Office with timely notice of the following qualifying events:

- your divorce from your spouse,
- loss of dependent status by a child, or
- the occurrence of a second qualifying event while your dependents are in an 18-month COBRA continuation period (see "Extended COBRA Coverage If a Second Qualifying Event Occurs" above).

You must also provide the Trust Fund Office with timely notice when:

- you and your dependents have experienced a qualifying event entitling you to COBRA Continuation Coverage with a maximum duration of 18 months and one of you is determined by the Social Security Administration to be disabled, or
- the Social Security Administration determines that the person is no longer disabled.

You must make sure that the Trust Fund Office is notified of any of the five occurrences listed above. *Failure to provide this notice within the time frames described below may prevent you and/or your dependents from obtaining or extending COBRA coverage.*

How to Notify the Trust Fund Office

Notice of any of the five situations listed above must be given to the Trust Fund Office in writing. You must send a letter to the Fund containing the following information:

- name of the qualified beneficiary,
- the Participant's name and ID number or social security number,
- the event for which you are providing notice and the date of the event (for example, the date of a dependent child's 26th birthday), and
- a copy of the final marital dissolution if the event is a divorce.

If you have any questions about how to notify the Fund of one of these events, please call the Trust Fund Office at (775) 826-7200 or Toll Free at (877) 826-5053.

Where to Send Your Notice

Notice of Qualifying Events should be sent to the Trust Fund Office at the following address:

Northern Nevada Laborers Health and Welfare Trust Fund
P.O. Box 11337
Reno, NV 89510.

When to Notify the Trust Fund Office

If you are providing notice of a divorce, a dependent child losing eligibility for coverage, or a second Qualifying Event, you must send the notice no later than 60 days after the date of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage. **Your COBRA rights will be forfeited if you do not notify the Trust Fund Office within these time frames.**

If you are providing notice of a Social Security Administration determination that you or your dependent is no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you or your dependent is no longer disabled.

Who Can Notify the Trust Fund Office

Notice may be provided by you or your dependents or any representative acting on behalf of you or your dependents. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if your spouse notifies the Trust Fund Office that your child has ceased to meet the definition of a dependent under the Plan, that single notice would satisfy the notification requirement.

Electing Continuation Coverage

After receiving your notice of a qualifying event, the Trust Fund Office will send you a notice of your right to choose continuation coverage with an election form, or, if you do not qualify for continuation coverage, a Notice of Unavailability of COBRA Coverage. These notices will be sent within 14 days of the date the Trust Fund Office receives your notice.

The Trust Fund Office will send you a notice after your employer notifies the Plan that your health care coverage has ended because your employment terminated, you died, have become entitled to Medicare, or if you have not met the eligibility requirements in a month. This notice will tell you when your eligibility will terminate and inform you and/or your Dependents of the right to choose continuation coverage, and provide you with an election form, or, if you do not qualify for continuation coverage, a Notice of Unavailability of COBRA Coverage. You must complete and return the election form if you want self-pay for COBRA continuation coverage beyond the termination of your eligibility.

You must sign and return the election form to the Trust Fund Office no later than 60 days after the date of your loss of eligibility or the date of the cobra notice from the Trust Fund Office (whichever is later) or you will not be eligible for cobra continuation coverage. COBRA rights will be forfeited if you or your Dependents do not file the COBRA election forms within this 60-day period.

You do not have to show that you are insurable to choose COBRA Continuation Coverage. If you do not choose continuation coverage, your health insurance coverage will end. However, your spouse and/or your eligible Dependents may elect continuation coverage, even if you do not.

Your initial continuation coverage will be identical to coverage provided to similarly situated Employees under the Plan on the day prior to the Qualifying Event. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

In considering whether to elect COBRA Continuation Coverage, you should take into account your right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer, or available through the Health Insurance Marketplace). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA Continuation Coverage if you pay for COBRA Continuation Coverage for the maximum time available to you.

Adding New Dependents

If, while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, have a child placed with you for adoption, or assume legal guardianship of a child, you may enroll that spouse or child for coverage for the balance of the period of your continuation coverage, by sending a completed enrollment form to the Trust Fund Office within 30 days after the birth, marriage or placement for adoption.

Any Qualified Beneficiary can add a new spouse or child to his or her COBRA Continuation Coverage, but the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to stay on COBRA Continuation Coverage longer if a second Qualifying Event occurs, are the natural, adopted or legal guardianship children of the former Employee.

Special enrollment for the balance of your COBRA period is also allowed for dependents who lose other coverage. For this to occur:

- Your dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- Your dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- You must enroll that dependent by sending an enrollment form to the Trust Fund Office within 30 days after the termination of the other coverage or contributions.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum continuation period allowed (18, 29 or 36 months, as applicable).

However, if you are on military service, your dependents may continue their coverage for an additional six months under the provisions of USERRA. During this six-month extension, they will not be entitled to certain COBRA rights, such as the right to an additional 18 months of coverage if a second Qualifying Event occurs.

COBRA Continuation Coverage will terminate before the end of the 18, 29 or 36-month period upon the occurrence of any of the following events:

- You or your Dependents fail to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments);
- You or your Dependents become covered under any other group medical plan after the date you elect COBRA coverage;
- You or your Dependents become entitled to Medicare Part A or Part B after the date of your COBRA election;
- The Fund no longer provides group health coverage to any of its Employees; or
- You or your Dependents have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your Dependents are no longer disabled.
- Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

COBRA Continuation Coverage will terminate on the first day of the month following the events listed above. However, if the termination is due to failure to pay the required premium, COBRA continuation coverage will terminate at the end of the month for which the premium was last paid and accepted.

If COBRA coverage is terminated before the end of the maximum period of coverage, the Trust Fund Office will send you a written notice as soon as practicable following its determination that continuation coverage will terminate.

Keeping the Trust Fund Office Notified

If you have changed marital status, or you or your spouse or other Dependents have changed addresses, please contact the Trust Fund Office. Please let the Trust Fund Office know of any Qualifying Event even if your Employer is otherwise required to give notice to the Trust Fund Office.

IMPORTANT NOTICE: Should federal or state law alter the provisions of COBRA in existence at the time this Summary Plan Description is printed, participants will be advised of these modifications as required.

COBRA Continuation Coverage Reference Chart

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
1) Insufficient work hours	You, your spouse and Dependent children	18 months after date of Qualifying Event*
2) Termination of your employment (for reasons other than gross misconduct)	You, your spouse and Dependent children	18 months after date of Qualifying Event*
3) Your death	Your spouse and Dependent children	36 months after date of Qualifying Event
4) Your divorce	Your spouse and Dependent children	36 months after date of Qualifying Event
5) Your child's loss of Dependent status under the Plan	Affected Dependent if covered under Plan	36 months after date of Qualifying Event

* If you or one of your eligible Dependents is disabled, COBRA Continuation Coverage may continue for the disabled person and eligible family members for up to 29 months. A higher premium will be charged for the additional 11 months of coverage.

If a second Qualifying Event that would result in a 36-month continuation coverage period occurs within the first 18-month period, COBRA Continuation Coverage for Dependents may be extended for up to a maximum of 36 months from the date of the first Qualifying Event.

COBRA Questions

If you have any questions about your COBRA rights, please contact the Trust Fund Office whose address is listed on the Quick Reference Chart at the front of this document.

Chapter 13

Claims Appeal Procedures

In This Chapter You'll Find
- Using an Authorized Representative
- Denied Claims (Adverse Benefit Determinations)
- Request for Appeal of an Adverse Benefit Determination
- Appeal Process
- Notice of Decision on Appeal
- Limitation on When a Lawsuit May Be Started

Discussed below are the steps involved in appealing an adverse decision on a filed claim with which you disagree. The processing times mentioned in the discussion are summarized in the charts at the end of the discussion.

Using an Authorized Representative

An authorized representative, such as your spouse, may complete the claim form and/or claim appeal for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request.
additional information to verify that this person is authorized to act on your behalf. Even if you have designated an authorized representative to act on your behalf, you must personally sign a claim form and file it with the Trust Fund Office at least annually.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an urgent care claim without your having to complete the special authorization form.

Denied Claims (Adverse Benefit Determinations)

You will be provided with written notice of an adverse benefit determination, whether your claim is denied in whole or in part. This notice will include the following:

1. the specific reason(s) for the determination
2. reference to the specific Plan provision(s) on which the determination is based
3. a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary.
4. a description of the appeal procedures and applicable time limits
5. if an internal rule, guideline, or protocol was relied upon in deciding your claim, either a copy of the rule or a statement that it is available upon written request at no charge.
6. if the determination was based on the absence of medical necessity, or the treatment's being experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge.

For urgent care claims, the notice will describe the expedited review process applicable to urgent care claims. For urgent care claims, the required determination may be provided orally and followed with written notification.

For an urgent care claim, you will receive notice of the determination even when the claim is approved.

Request for Appeal of an Adverse Benefit Determination

If you disagree with the decision made on a claim, you may ask for an appeal (also known as a review). Your request for appeal must be made in writing to the Trust Fund Office as follows:

1. within 180 days after you receive the notice of denial for a claim involving health care (including medical, prescription drug, dental or vision benefits) or disability (or, in the case of a concurrent care decision, within a reasonable time, given the medical exigencies of your situation)
2. within 60 days after you receive the notice of denial for other claims

The Trust Fund Office may refer your appeal for life insurance or AD&D to the insurance company. You may appeal an adverse benefit determination regarding urgent care by faxing your request to the Utilization Review representative at (775) 826-7289, calling the Trust Fund Office at (775) 826-7200 or Toll Free at (877) 826-5053, or going to the Trust Fund Office and asking to speak to the Utilization Review representative.

Appeal Process

The appeal process works as follows:

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if it was relied upon by the Trust Fund Office in making the decision; it was submitted, considered, or generated (regardless of whether it

was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Trust Fund Office on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim on appeal than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments as may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Notice of Decision on Appeal

You will receive notice of the decision made on your Appeal according to the following timetable:

1. **Urgent care claims**: You will be sent notice of a decision on appeal within 72 hours of receipt of the appeal by the Trust Fund Office.
2. **Concurrent care claims**: You will receive notice of a decision on appeal within a reasonable time for the type of care decision.
3. **Post-service health care claims**: Ordinarily, decisions on appeals involving post-service claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for appeal. However, if your request for appeal is received less than 30 days before the next regularly scheduled meeting, your request for appeal may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for appeal may be necessary. You will be advised in writing in advance if this extension is necessary. Once a decision on appeal of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.
4. **Disability claims**: Decisions on appeals will be made at Board of Trustees meetings. The timing and procedures are the same as those described immediately above for post-service health care claims.
5. **Other claims**: Decisions will ordinarily be made within 60 days of receipt of appeal by the Trust Fund Office or by the insurance company for life, or AD&D benefits. The period for making a decision may be extended by up to 60 days, provided the Trust Fund Office or the insurance company notifies you, prior to the expiration of the first 60 days, of the circumstances requiring the extension and the date as of which it expects to render a decision.

The decision on any appeal of your claim will be given to you in writing no later than 5 calendar days after the benefit determination is made. The notice of a denial of a claim on appeal will include the following:

1. the specific reason(s) for the determination
2. reference to the specific Plan provision(s) on which the determination is based
3. a statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.
4. a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal
5. if an internal rule, guideline, or protocol was relied upon by the Trust Fund Office, either a copy of the rule or a statement that it is available upon written request at no charge.
6. if the determination was based on medical necessity, or the treatment's being experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge.

Limitation on When a Lawsuit May Be Started

You or any other claimant may not start a lawsuit to obtain benefits, including proceedings before courts or administrative agencies, until after you have requested an appeal and a final decision has been reached on appeal (or until the appropriate time frame described above has elapsed since you filed a request for appeal and you have not received a final decision or notice that an extension will be necessary to reach a final decision) for every issue deemed relevant by the claimant.

No lawsuit may be started against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with an adverse action or appeal denial more than one (1) year after:

1. the date a health care claim on appeal has been denied or, if no appeal has been filed, the date on which the adverse health care

claim decision was made (for health care benefits);

2. the start of the disability (for disability benefits), or
3. the date of death or other loss (for life and AD&D insurance benefits).

Under this Plan a health care provider/facility is not a claimant that is permitted to start a lawsuit or other legal action to obtain Plan benefits.

Maximum Times for Processing of Health Care Claim Appeals			
	Urgent Care Claims	**Concurrent Care Claims**	**Post-Service Claims**
You make request for appeal	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial
Trust Fund Office/Board makes decision on appeal	Within 72 hours of receiving your request for appeal	Within a reasonable time for type of care decision	At next regular Board meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)

Maximum Times for Processing of Disability and Other Claim Appeals		
	Disability Claims	**Other Claims**
You make request for appeal	Within 180 days of receiving notice of denial	Within 60 days of receiving notice of denial
Board or insurance company makes decision on appeal	At next regular Board meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)	Within 60 days of receiving your request for appeal (can be extended another 60 days)

Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, the Board of Trustees, the Appropriate Claims Administrator nor any other designee of the Board will be required to see to the application of the money so paid.

Chapter 14
Important Federal Mandates & Notices

Discussed below are federal mandates, reminders and notices.

In This Chapter You'll Find
- Patient Protection & Affordable Care Act rights
- Newborns and Mothers Health Protection Act rights
- The Women's Health and Cancer Right's Act
- Mental Health Parity & Addiction Equity Act rights
- Surprise Billing Protections

The Patient Protection and Affordable Care Act

▪ **Grandfathered Plan.** The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other non-grandfathered plans, 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 ACA, such as the elimination of annual and lifetime dollar limits on the Plan's Essential Health Benefits. (For a definition of what constitutes 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 Fund Manager. 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.

▪ **No Pre-Existing Condition Exclusions for Any Individual.** The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions.

▪ **Dependent Child(ren) Coverage Up to Age 26.** In accordance with the ACA, the Plan will permit a Participant's eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his/her own employer-sponsored group health plan (or his/her Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

▪ **Minimum Essential Coverage.** Under the ACA, Plan sponsors are required to provide minimum essential coverage. Minimum essential coverage includes jointly sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

▪ **Availability of Summary of Benefits & Coverage ("SBC").** The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC," to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge. If you want a copy of the Plan's self-funded Plan SBC, please call the Trust Fund Office or visit the website 169laborers.com.

▪ **Elimination of Lifetime and Annual Dollar Limits on Essential Health Benefits.** The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion.

▪ **Prohibition of Rescissions of Coverage.** Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or your and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

▪ **For More Health Care Reform Information.** Please visit the U.S. Department of Labor website at *www.dol.gov/ebsa/healthreform* for more information about the ACA's provisions.

The Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), as amended is a federal law that prevents self-funded group health plans (such as this Plan) and fully-insured group health plans (through the 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) and treatment limitations (e.g., number of visits or days of coverage) 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. Furthermore, plans and insurers may not impose any Non-Quantitative Treatment Limitation ("NQTL") with respect to mental health/substance abuse benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical and surgical benefits in the same classification.

Pursuant to the MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, 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 will also be provided upon request. Furthermore, upon request any participant, beneficiary or enrollee (or its authorized representatives) who has received an adverse benefit determination related to mental health or substance abuse benefits, can request a copy of the Plan's comparative analysis (for MHPAEA compliance) at any time.

It is the intention of the Board of Trustees and the contracted insurers that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations and guidance issued thereunder. It is also the intention of the Board of Trustees that benefits are not designed to impose a greater burden on access to mental health/substance use disorder benefits compared to medical/surgical benefits offered under the terms of the Plan. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa*. Please also contact the Trust Fund office for the most up-to-date provider directory to access a mental health or substance use disorder benefits provider.

The Newborns and Mothers Health Protection Act

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by Caesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your physician), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal Law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services for eligible participants and dependents. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- All stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola regimentation to restore the physical appearance of the breast, as a required stage of reconstruction).

- Surgery and reconstruction to achieve symmetry between the breasts.

- Prostheses, and
- Physical complications resulting from all stages of a mastectomy (including lymphedema).

They are subject to the Plan's usual deductible and coinsurance provisions.

Consolidated Appropriations Act of 2021- Surprise Billing Protections

The Plan is required to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA. The Plan's providers are also required to comply with these new provisions.

Participants and dependents are prohibited from being balance billed for

(1) out-of-network emergency services,

(2) non-emergency services performed by an out-of-network provider received at in-network facility, and

(3) out-of-network air ambulance services (if covered).

Providers are prohibited from holding patients liable for excess amounts not covered by the Insured coverage.

Patient Protections Disclosure Requirements Against Balance Billing. The Plan and Providers are required to make publicly available, by posting on the website of the Provider and Plan and including on each Explanation of Benefits for an item or service as it relates to: (1) emergency services or (2) non-emergency services provided by non-participating provider at in-network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the participant or dependent believes the provider/facility has violated the No Surprise Act provisions.

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 protection 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:

o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

o Cover emergency services by out-of-network providers.

o 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.

o 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.

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.

Chapter 15
Other Important Plan Information

In This Chapter You'll Find
- Plan Facts
- Statement of ERISA Rights
- General Plan Provisions
- Assignment of Benefits
- Discretionary Authority of Board of Trustees
- Not a Contract of Employment
- Plan Amendment or Termination
- Factors that Could Affect Your Receipt of Benefits
- Third Party Liability
- Notice of Privacy Practices

Plan Facts

Name of Plan	Northern Nevada Laborers Health and Welfare Trust Fund
Employer Identification Number (EIN)	88-6031748
Type of Plan	Employee welfare benefit plan providing life insurance, accidental death and dismemberment insurance, weekly disability income, comprehensive major medical, prescription drug, dental, and vision care benefits.
Plan Number	501
Funding Medium	All benefits are paid directly from Fund assets, except that The Union Labor Life Insurance Company receives premiums to provide life insurance and accidental death and dismemberment benefits.
Source of Contributions	The Fund is funded through employer contributions, the amount of which is determined by collective bargaining agreements. Some participants are allowed to contribute on their own behalf, as described. in Chapter 2 of this SPD.
Plan Year	The date of the end of the Plan year is August 31.
Plan Sponsor	Upon written request, the Trust Fund Office will provide any covered person or beneficiary information as to whether a particular employer is contributing to the Trust Fund and, if so, that contributing employer's address.
Plan Administrator	The Board of Trustees Northern Nevada Laborers Health and Welfare Trust Fund 445 Apple Street, Suite 109 Reno, Nevada 89502 Telephone: (775) 826-7200 Toll Free: (877) 826-5053 The Board is made up of trustees appointed by the participating employers and by the Union.
Agent for Service of Legal Process	Richard K. Grosboll & Lois H. Chang Neyhart Anderson Flynn & Grosboll APC Each member of the Board of Trustees is an agent for the purpose of accepting service of legal process on behalf of this Plan. For disputes arising under those portions of the Plan insured by the Union Labor Life Insurance Company, service of legal process may be made upon ULLICO at the address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the State Insurance Department.

Type of Administration

The Northern Nevada Laborers Health and Welfare Trust Fund self-funds group health plan for Eligible medical expenses, dental expenses, vision expenses, and short-term disability income benefits under the Plan. Claims for these benefits are administered by independent claims administrators as listed on the Quick Reference Chart in the front of this document. The funding for the benefits is derived from Employer contributions made on behalf of covered employees. The Plan is not insured.

The Union Labor Life Insurance Company administers the fully insured benefits of this Plan (including life insurance and accidental death and dismemberment benefits) and provides payment of claims associated with these benefits.

Plan Administrator/Plan Sponsor

The Plan is administered and maintained by a joint labor-management Board of Trustees, with the assistance of Benefit Plan Administrators, Inc., a contract administration organization. The address and telephone number of the Trust Fund Office of the Trust Fund are as follows:

The Board of Trustees
Northern Nevada Laborers Health and Welfare Trust Fund
c/o Benefit Plan Administrators, Inc.
445 Apple Street, Suite 109
Reno, Nevada 89502
Telephone: (775) 826-7200
Toll Free: (877) 826-5053

The Trust Fund Office is staffed with people competent in the fields of accounting, data processing, and claims processing. The contract administration organization bills all participating employers monthly, receives the employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records of all reported employees, and receives all claims filed by participating employees.

Copies of plan documents may be obtained by writing to the Plan Administrator at the address above.

Claims Appeal Fiduciary (Claims Administrator)

With respect to all matters regarding eligibility:
Northern Nevada Laborers Health and Welfare Trust Fund
445 Apple Street, Suite 109
Reno, Nevada 89502
Telephone: (775) 826-7200
Toll Free: (877) 826-5053

With respect to adjudication of claims under the medical, outpatient prescription drug, dental, vision, or weekly disability programs:
Northern Nevada Laborers Health and Welfare Trust Fund
445 Apple Street, Suite 109
Reno, Nevada 89502
Telephone: (775) 826-7200
Toll Free: (877) 826-5053

With respect to adjudication of claims under life insurance or accidental death and dismemberment benefits:
The Union Labor Life Insurance Company
8403 Colesville Road 13th Floor
Renee -Life Claims Mail Stop #709
Silver Spring, MD 20910

Benefit Programs	Funding	Claims Administrator as listed on the Quick Reference Chart in the front of this document
Medical Plans	Self-funded	Trust Fund Office
Prescription Drug Benefits	Self-funded	OptumRx/Trust Fund Office
Dental Plan	Self-funded	Trust Fund Office
Vision Plan	Self-funded	Trust Fund Office
Life and AD&D Insurance	Insured	The Union Labor Life Insurance Company
Weekly Disability	Self-funded	Trust Fund Office

Plan Documents

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Trust Fund Office during regular business hours. Upon written request, copies of these documents will be provided.

The Trustees may make a reasonable charge for the copies. The Plan Administrator will state the charge for specific documents on request, so you may know the cost before ordering.

Collective Bargaining Agreements

This program is maintained pursuant to various collective bargaining agreements. Copies of collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours and will be furnished by mail upon written request. A copy of any collective bargaining agreement providing for contributions to the Trust Fund is available for inspection within 10 calendar days after written request at any Local Union office or any contributing employer to which at least 50 Plan participants report each day.

Funding Medium

The weekly disability income, comprehensive major medical, prescription drug, dental, and vision care benefits are provided directly from Trust Fund assets. The complete terms of the benefits provided directly by the Fund are set forth in the Rules and Regulations of the Plan.

Life insurance and accidental death and dismemberment coverage are provided under a contract with The Union Labor Life Insurance Company (ULLICO). The complete terms of the benefits provided are set forth in the insurance policies or service agreements with this company.

Contribution Source

All contributions to the Plan are made by employers in accordance with Collective Bargaining Agreements and participation agreements between the Northern Nevada Laborers Health and Welfare Trust Fund and employers in the industry. The Collective Bargaining and participation Agreements require contributions to the Plan at a fixed rate per hour worked. The Trust Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Eligible Persons working under a Collective Bargaining Agreement, additional information about the Collective Bargaining Agreements, and the Fund's investment of assets and checking accounts.

Future of the Plan and Trust Fund

The Board of Trustees is providing this program of benefits to the extent that monies are currently available to pay the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditures of such monies for the program. This is not a guaranteed lifetime benefit program, nor are benefits guaranteed to continue indefinitely.

Plan Amendment or Termination

Although the Board currently intends to continue the Plan, it is under no legal obligation to do so. Accordingly, the Board reserves the right, solely at its discretion, to amend or terminate the Plan at any time without advance notice to participants. This includes the discretionary right to interpret, revise, supplement or rescind any or all portions of the Plan.

This right includes, but is not limited to,

1. To terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
2. To alter or postpone the method or payment of any benefit; and
3. To amend or rescind any other provisions of the Plan.

Amendments to the Plan may be made in writing and become effective on the written approval of the Board of Trustees.

Such termination or amendment may affect the amount of any benefit payable for charges incurred before the effective date of such changes or termination.

The Plan or any coverage under it may be terminated by its Board of Trustees, and new coverages may be added by its Board of Trustees. Upon termination, discontinuance or revocation of participation in the Plan, all elections and reductions in compensation related to the Plan will terminate.

The Trust Fund will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund.

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Statement of ERISA Rights

As a participant in the Plan of the Northern Nevada Laborers Health and Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information About Your Plan and Benefits

1. 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.
2. 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 Plan Administrator may make a reasonable charge for the copies.
3. 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.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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.

Enforce Your Rights

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 a 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan’s Claims Filing and Review information on the requirement to appeal a denied claim and exhaust the Plan’s appeal process before filing a lawsuit.

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 a 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.

Assistance with Your Questions

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 Security 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 Toll Free at 1.866.444.EBSA(3272)

General Plan Provisions Assignment of Benefits

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. A direction to pay a provider is not an assignment of any right under this Plan, or authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, or an assignment of fiduciary duty, or an assignment of any legal or equitable right to institute any court proceeding.

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

Discretionary Authority of Board of Trustees

In carrying out their respective responsibilities under the Plan, the Board of Trustees have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The

The Plan Administrator also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Any interpretation or determination by the Board, made in good faith, which is not contrary to the law, is conclusive to all persons affected.

Authority

Any dispute as to eligibility, type, amount, or duration of benefits or any right or claim to payments from the Fund shall be resolved by the Board or its duly authorized designee in accordance with the Rules and Regulations and the Trust Agreement. In the event of any conflict between this booklet and the Rules and Regulations, the Rules and Regulations will prevail. In the event of a conflict between either this booklet or the Rules and Regulations and the Trust Agreement, the provisions of the Trust Agreement will prevail.

Any suit, action or proceeding arising out of, or with respect to, the Plan, the Rules and Regulations, the Summary Plan Description, the Trust Agreement and any other document or agreement under which the Fund is governed shall be filed in a court of competent jurisdiction within the County of Washoe, State of Nevada or in the U.S. District Court for the District of Nevada, Northern Division. By participating in the Fund, each Employee and each dependent, and all of their respective assignees, consent to the personal jurisdiction of such courts within the County of Washoe, State of Nevada and the U.S. District Court for the District of Nevada, Northern Division, and waive any objections to venue in such courts within Washoe County, State of Nevada and the U.S. District Court for the District of Nevada, Northern Division.

Any assignment that is permitted and made under the Rules and Regulations shall, notwithstanding any provision in the assignment to the contrary, be governed by Nevada and federal law and shall be subject to Nevada venue. Therefore, any suit, action or proceeding arising out of, or with respect to, any assignment that is permitted and made under the Rules and Regulations or any rights assigned in such assignment, shall be filed in a court of competent jurisdiction within the County of Washoe, State of Nevada or in the U.S. District Court of Nevada, Northern Division. Moreover, no Employee or Dependent may make any assignment that in any way contradicts venue in a court of competent jurisdiction within the County of Washoe, State of Nevada or in the U.S. District Court for the District of Nevada, Northern Division.

All benefits provided by this Plan are payable at the Trust Fund office in Reno, Nevada. See Chapter 13: Claims Appeal Procedures for information on what to do if you disagree with the decision made in regard to a claim you have filed. For information on limitations on when you may start a lawsuit to obtain benefits see "Limitation on When a Lawsuit May Be Started" beginning on page 70.

Right to Recover Excess Payments/Overpayments

If you or your dependent(s) receives any overpayment of benefits from the Fund, whether by mistake or otherwise, then the Fund shall have the right to recover from the you and your dependent(s), if any, the full amount of the overpayment of benefits together with all costs of collection, including reasonable attorneys' fees and costs. No benefits will be paid for fraudulent premiums, claims of services, or supplies made by a Participant, eligible Dependent, or any other person or for any other reasons (including, but not limited to enrolling an ineligible Dependent under the Plan, failing to notify the Plan that a previously eligible Dependent no longer qualifies as a Dependent, or failure to timely enroll in Medicare). If payment, on behalf of any person, both the Participant and any person on whose behalf a fraudulent claim was submitted will be liable to the Plan for repayment. The Fund has the right to reduce future payments due to you and your dependent(s) by the amount of the overpayment of benefits. This right of offset shall not limit any other rights of the Fund to recover the amount of any overpayment of benefits.

Right to Examinations

The Fund has the right and opportunity to require as many examinations as reasonably necessary during the claims process (including an autopsy, unless prohibited by law). Such examinations would be at the Fund's expense.

Right to Freedom from Liability for Payment

There is no liability on the Board or any other individual or entity to provide payments over and beyond the amounts in the Trust Fund collected and available for such purposes. Any benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for payment.

No Replacement for Workers' Compensation

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage under Workers' Compensation insurance laws or similar legislation.

Not a Contract of Employment

Your participation in the Plan does not guarantee your continued employment with any contributing employer. The Plan is not an employment contract.

Nothing in the Plan gives you a right to employment or affects the rights of a contributing employer to terminate your employment at any time.

No Liability for Practice of Medicine

The Plan, Plan Administrator or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any Health Care Provider. Neither the Plan, Plan Administrator, nor any of their designees, will have any liability whatsoever for any loss or injury caused to you by any Health Care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Factors that Could Affect Your Receipt of Benefits

Certain factors could interfere with payment of benefits from the Plan (result in your disqualification or ineligibility; denial of your claim; or loss, forfeiture, or suspension of benefits you might reasonably expect). Examples of such factors include the following:

- Performance of work for a non-contributing employer or consent to under-contributing. If you are under the hour bank system and you perform work covered by the Laborers Union Local 169 or Operative Plasterers & Cement Masons Union Local 797 collective bargaining agreements for an employer that is not a contributing employer or you knowingly permit a contributing employer to contribute to the Fund for less than all of the hours you have worked, all remaining hours in your hour bank will immediately be canceled.
- Failure to submit claims in a timely way. All claims should be filed within 90 days following the date of service. The claim must be received within one (1) year from the date of service.
- The Plan's provisions for coordination of health care benefits. If you or a dependent has health care coverage under another plan, payment of benefits by the Fund will be coordinated with payment of benefits by that other plan. See "Coordination of Benefits" in chapter 11 for more information.

- The Plan's subrogation provision. You must reimburse the Fund for any benefits you receive for an illness or injury caused by a third party if you are compensated for that illness or injury by the third party or an insurer. See Third Party Liability on page 82 for more information.
- Failure to update your address or enrollment card. If you move, it is your responsibility to keep the Trust Fund Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Trust Fund Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Trust Fund Office that you have divorced, or a child has ceased to be an eligible dependent). In addition, you may be liable for other costs incurred by the Fund as a result of the incorrect information. These costs include (but are not limited to) attorneys' fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Trust Fund Office at (775) 826-7200 or Toll Free at (877) 826-5053.

Third Party Liability

The Fund shall be entitled to subrogation and/or reimbursement of all rights of recovery of a Participant, Dependent, and representative, guardian, trustee, agent, or assignee of such Participant and/or Dependent (collectively, "Claimant"). The Fund shall be subrogated to any and all rights of recovery and causes of action, whether by suit, settlement or otherwise, that Claimant may have against any person or entity that may be liable for Claimant's Injury, sickness or condition for which the Fund has paid or may be obligated to pay benefits on Claimant's behalf. Claimant shall execute and deliver instruments and papers and whatsoever else is necessary to secure such rights. Claimant shall not do anything to impair, release, discharge or prejudice the Fund's rights to subrogation and/or reimbursement.

That the Fund shall also be entitled, to the full extent of payments made or to be made by the Fund to or on behalf of Claimant, to the proceeds of any settlement, judgment or payment from any source liable for making a payment relating to Claimant's Injury, sickness or condition for which the Fund has paid or is obligated to pay benefits on Claimant's behalf. A source includes, without limitation, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, and an individual policy of insurance maintained by Claimant. In the event of a recovery or settlement, the Fund shall be reimbursed out of such recovery or settlement for all expenses, costs and attorneys' fees incurred by the Fund in connection therewith.

Claimant shall hold in trust for the Fund's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Fund immediately upon recovery. Claimant shall immediately notify the Fund if Claimant is involved in or suffers an accident or injury for which a third party may be liable. Claimant shall again notify the Fund if Claimant pursues a claim to recover damages or other relief relating to an Injury, sickness or condition for which the Fund has paid or is obligated to pay benefits on Claimant’s behalf. Claimant shall immediately notify the Fund upon receiving a judgment, settlement offer, or other compromise offer, and upon filing any petition to compromise a minor's claim. Claimant shall not settle or compromise any claims without the Fund's consent.

The Trust Fund's subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery, whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether Claimant is made whole and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses. The Fund shall be entitled, to the full extent of any payment made or to be made to or on behalf of Claimant, to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of Claimant against any person or entity for the Injury, sickness or condition for which such payment was made or will be made. The Fund shall be entitled to complete reimbursement for all benefits paid and to be paid regardless of attorneys' fees or costs incurred by Claimant in obtaining any settlement or judgment.

Once the Fund makes or is obligated to make payments on behalf of Claimant, the Fund is granted, and Claimant consents to, an equitable lien by agreement and/or a constructive trust on the proceeds of any payment, settlement, or judgment received by or on behalf of Claimant from any source to the full extent of payments made or to be made by the Fund on Claimant's behalf.

Neither the make whole rule, the common fund doctrine, nor any other federal or state common law defense shall in any way reduce or limit the Fund's reimbursement, subrogation, and other rights under this Third-Party Liability Section. The Fund's reimbursement, subrogation, and other rights under this Third-Party Liability Section may not be adjudicated or modified through a compromise of a minor's claim pursuant to NRS 41.200 or other comparable statute.

The Fund may require Claimant to complete and execute certain documentation to assist the Fund in the enforcement of its subrogation and reimbursement rights including, without limitation, a subrogation and reimbursement questionnaire and a reimbursement agreement. The completion and execution of any documents requested by the Fund shall be a condition precedent to receiving payment for a claim. If Claimant fails to complete and execute such documentation, the Fund shall have the right to suspend all benefit payments that would otherwise be due to Claimant, the Participant of whom Claimant is a dependent and any other dependent of Claimant or such Participant.

The Fund may cease advancing benefits if there is a possible basis to determine this provision may not be enforceable, or if there is a basis to believe that Claimant will not honor the terms of this Third-Party Liability Section. The Fund may also deny coverage for expenses incurred after recovery on the third-party claim, if such expenses are related to the third-party recovery. If the Fund is not reimbursed upon recovery on a claim, the Fund or its Trustees may bring an action against any Claimant to enforce the Fund's right to reimbursement and/or the agreement to reimburse, and/or to seek a constructive trust or other remedy. In addition, without waiving any other remedy, the Fund may recoup the reimbursement by recovering from the source to which benefits were paid and/or by offsetting against future benefit payments that would otherwise be due to Claimant, the Participant of whom Claimant is a dependent and any other dependent of Claimant or such Participant.

Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review this information carefully.

This Notice is required by law.

The Northern Nevada Laborers Health and Welfare Trust Fund's self-funded group health plan including the medical plan including outpatient prescription drug benefits, dental plan, vision plan and COBRA administration, (hereafter referred to as the "Plan"), Is required by law to take reasonable steps to maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI)** and to inform you about the Plan's legal duties and privacy practices with respect to protected health information including:

- The Plan's uses and disclosures of PHI,
- Your rights to privacy with respect to your PHI,
- The Plan's duties with respect to your PHI,
- Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS), and
- The person or office you should contact for further information about the Plan's privacy practices.
- To notify affected individuals following a breach of unsecured protected health information.

PHI use and disclosure by the Plan is regulated by the Federal law, Health Insurance Portability and Accountability Act; commonly called HIPAA. You may find these rules in 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize key points in the regulation. The regulations will supersede this Notice if there is any discrepancy between the Information in this Notice and the regulations. The Plan will abide by the terms of the Notice currently in effect. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains.

This Privacy Notice pertains to your protected health information held by the Northern Nevada Laborers Health and Welfare Trust Fund's self-funded group health plan (the "Plan") and outside companies contracted to help administer Plan benefits, also called "business associates."

Effective Date

The effective date of this last Notice is June 1, 2017, and this notice replaces notices previously distributed to you.

Privacy Officer

The Plan has designated a Privacy Officer to oversee the administration of privacy by the Plan and to receive complaints. The Privacy Officer may be contacted at:

Privacy Officer for the Northern Nevada Laborers Health and Welfare Trust Fund
445 Apple Street, Suite 109- Reno, NV 89502
Phone: (775) 826-7200
Toll Free: (877) 826-5053

Your Protected Health Information

The term **"Protected Health Information" (PHI)** Includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI does not include health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family or Medical Leave (FMLA), life insurance, drug testing, etc.

This Notice does not apply to information that has been de-identified. **De-Identified Information** is information that does not identify you, and with respect to which there is no reasonable basis to believe that the information can be used to identify you, is not individually identifiable health information.

When the Plan May Disclose Your PHI

Under the law, the Plan may disclose your PHI without your written authorization in the following cases:

- *At your request.* If you request it, the Plan is required to give you access to your PHI in order to inspect it and copy it.
- *As required by an agency of the government.* The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- *For treatment, payment or health care operations.* The Plan and its business associates will use your PHI (except psychotherapy notes in certain instances as described below) without your consent, authorization for opportunity to agree or object in order to carry out treatment, payment, or health care operations.

The Plan does not need your consent or authorization to release your PHI when you request it, a government agency requires it, or the Plan uses it for treatment, payment or health care operations.

The Plan Sponsor has **amended its Plan documents** to protect your PHI as required by Federal law. The Plan may disclose PHI to the Plan Sponsor for purposes of treatment, payment and health care operations in accordance with the Plan amendment. The Plan may disclose PHI to the- Plan Sponsor for review of your appeal of a benefit or for other reasons related to the administration of the Plan.

Definitions and Examples of Treatment, Payment and Health Care Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but Is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers. • ***For example:*** The Plan discloses to a treating specialist the name of your treating primary care physician so the two can confer regarding your treatment plan.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making payment for the provision of health care, determination of eligibility, claims management, and utilization review activities such as the assessment of medical necessity and appropriateness of care. • ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment, such as a claims payer, we will disclose pertinent information to them. These third parties are known as "business associates."
Health Care Operations keep the Plan operating soundly.	Health care operations include but is not limited to quality assessment and improvement, patient safety activities, business planning and development, reviewing competence or qualifications of health care professionals, underwriting, enrollment, premium rating and other Insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions Including fraud and abuse compliance programs and general administrative activities. • ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

Generally, the Plan will require that you sign a valid authorization form in order to use or disclose your PHI **other than:**

- When you request your own PHI
- A government agency requires it, or
- The Plan uses it for treatment, payment or health care operation.

You have the right to revoke an authorization.

Although the Plan does not routinely obtain psychotherapy notes, generally, an authorization will be required by the Plan before the Plan uses or discloses psychotherapy notes about you. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan generally will require an authorization form for uses and disclosure of your PHI for the pension plan and for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed. The Plan generally will require an authorization form for the sale of protected health information if the Plan receives direct or indirect financial remuneration (payment) from the entity to whom the PHI is sold. The Plan does not intend to engage in fundraising activities.

Use or Disclosure of Your PHI Where You Will Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Note that PHI obtained through Plan administration activities will NOT be used for employment related decisions.

Use or Disclosure of Your PHI Where Consent, Authorization or Opportunity to Object Is Not Required

In general, the Plan does not need your written authorization to release your PHI if required by law or for public health and safety purposes. The Plan and its Business Associates are allowed to use and disclose your PHI **without** your written authorization (in compliance with section 164.512) under the following circumstances:

1. When **required by law.**
2. When permitted for **purposes of public health activities.** This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. To a school about an individual who is a student or prospective student of the school if the protected health information is disclosed is limited to **proof of immunization,** the school is required by State or other law to have such proof of immunization prior to admitting the individual and the covered entity obtains and documents the agreements to this disclosure from either a parent, guardian or other person acting in loco parentis of the individual, if the individual is an unemancipated minor; or the individual, if the individual is an adult or emancipated.
4. When authorized by law to report information about **abuse, neglect or domestic violence** to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such a case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice causes a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under Federal or state law when the parents or other representatives may not be given access to the minor's PHI.
5. To a public health oversight agency for **oversight activities authorized by law.** These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
6. When required **for judicial or administrative proceedings**. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:
    - the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written Notice, and
    - the Notice provided sufficient information about the proceeding to permit you to raise an objection, and
    - no objections were raised or were resolved in favor of disclosure by the court or tribunal.
7. When required for **law enforcement health purposes** (for example, to report certain types of wounds).
8. For **law enforcement purposes** if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:
    - identifying or locating a suspect, fugitive, material witness or missing person, and
    - disclosing information about an individual who is or is suspected to be a victim of a crime.

9. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. When required to be given to funeral directors to carry out their duties with respect to the decedent; for use and disclosures for cadaveric **organ, eye or tissue donation** purposes.
10. For **research**, subject to certain conditions.
11. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and **imminent threat to the health or safety** of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with **workers' compensation** or other similar programs established by law.
13. When required, for **specialized government functions**, to military authorities under certain circumstances, or to authorized Federal officials for lawful intelligence, counterintelligence and other national security activities.

Any other Plan uses and disclosures not described in this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization, and information used and disclosed will be made in compliance with the minimum necessary standards of the regulation.

Your Individual Privacy Rights

A. You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict the uses and disclosures of your PHI:

- To carry out treatment, payment or health care operations, or
- To family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request if the Plan Administrator or Privacy Officer determines it to be unreasonable, for example, if it would interfere with the Plan's ability to pay a claim.

The Plan will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual. You or your personal representative will be required to complete a form to request restrictions on the uses and disclosures of your PHI. To make such a request contact the Privacy Officer at their address listed on page 83.

B. You May Inspect and Copy Your PHI

You have the right to inspect and obtain a copy (in hard copy or electronic form) of your PHI (except psychotherapy notes and information compiled in reasonable contemplation of an administrative action or proceeding) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hard copy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You may also request a summary of your PHI.

A Designated Record Set includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included in the designated record set.

The Plan must provide the requested information within 30 days of its receipt of the request, if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information.

You or your personal representative will be required to complete a form to request access to the PHI in your Designated Record Set. Requests for access to your PHI should be made to the Plan's Privacy Officer at their address listed on page 83. You may be charged a reasonable cost-based fee for creating or copying the PHI or preparing a summary of your PHI.

If access is denied, you or your personal representative will be provided with a written denial describing the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Plan's Privacy Officer or the Secretary of the U.S. Department of Health and Human Services.

C. You Have the Right to Amend Your PHI

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline (provided that the Plan notifies you in writing in advance of the reasons for the delay and the date by which the Plan will provide the requested information).

If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. You should make your request to amend PHI to the Privacy Officer at their address listed on page 83.

You or your personal representative may be required to complete a form to request amendment of your PHI. Forms are available from the Privacy Officer at their address listed on page 83.

D. You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years (or shorter period if requested) before the date of your request. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. The Plan has 60 days after its receipt of your request to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

E. You have the Right to Request that PHI be Transmitted to You Confidentially

The Plan will permit and accommodate your reasonable request to have PHI sent to you by alternative means or to an alternative location (such as mailing PHI to a different address or allowing you to personally pick up the PHI that would otherwise be mailed), if you provide a written request to the Plan that the disclosure of PHI to your usual location could endanger you. If you believe you have this situation, you should contact the Plan's Privacy Officer to discuss your request for confidential PHI transmission.

F. You Have the Right to Receive a Paper or Electronic Copy of This Notice Upon Request

To obtain a paper or electronic copy of this Notice, contact the Plan's Privacy Officer at their address listed on page 83. This right applies even if you have agreed to receive the Notice electronically.

G. Breach Notification

If a breach of your unsecured protected health information occurs, the Plan will notify you.

Your Personal Representative

You may exercise your rights to your protected health information (PHI) by designating a person to act as your Personal Representative. Your Personal Representative will generally be required to produce evidence (proof) of the authority to act on your behalf **before** the Personal Representative will be given access to your PHI or be allowed to take any action for you. Under this Plan, proof of such authority will include (1) a completed, signed and approved Appoint a Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) a court appointed conservator or guardian; or, (4) for a Spouse under this, Plan, the absence of a Revoke a Personal Representative form on file with the Privacy Officer.

This Plan will automatically recognize your legal Spouse as your Personal Representative and vice versa without you having to complete a form to Appoint a Personal Representative. However, you may request that the Plan not automatically honor your legal Spouse as your Personal Representative by completing a form to Revoke a Personal Representative (available from the Privacy Officer).

- If you wish to revoke your Spouse as your Personal Representative, please complete the Revoke a Personal Representative form and return it to the Privacy Officer and this will mean that this Plan will NOT automatically recognize your Spouse as your Personal Representative and vice versa.

The recognition of your Spouse as your Personal Representative (and vice versa) is for the use and disclosure of PHI under this Plan and is not intended to expand such designation beyond what is necessary for this Plan to comply with HIPAA privacy regulations.

You may obtain a form to Appoint a Personal Representative or Revoke a Personal Representative by contacting the Privacy Officer at their address listed on page 83. The Plan retains discretion to deny access to your PHI to a Personal Representative to

provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Because HIPAA regulations give adults certain rights and generally children age 18 and older are adults, if you have dependent children age 18 and older covered under the Plan, and the child wants you, as the parent(s), to be able to access their protected health information (PHI), that child will need to complete a form to Appoint a Personal Representative to designate you (the employee/retiree) and/or your Spouse as their Personal Representatives. Contact the Privacy Officer for a form to Appoint a Personal Representative.

The Plan will consider a parent, guardian, or other person acting in loco parentis as the Personal Representative of an unemancipated minor (a child generally under age 18) unless the applicable law requires otherwise. In loco parentis may be further defined by state law, but in general it refers to a person who has been treated as a parent by the child and who has formed a meaningful parental relationship with the child for a substantial period of time. Spouses and unemancipated minors may, however, request that the Plan restrict PHI that goes to family members as described above under the section titled "Your Individual Privacy Rights."

The Plan's Duties

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with Notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and the terms of this Notice and to apply the changes to any PHI maintained by the Plan. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes.

Notice Distribution: The Notice will be provided to each person when they initially enroll for benefits in the Plan (the Notice is provided in the Plan's Initial Enrollment/New Employee benefits materials). The Notice will also be provided upon request. Once every three years the Plan will notify the individuals then covered by the Plan where to obtain a copy of the Notice. This Plan will satisfy the requirements of the HIPAA regulation by providing the Notice to the named insured (covered employee) of the Plan; however, you are encouraged to share this Notice with other family members covered under the Plan.

Notice Revisions: If a privacy practice of this Plan is changed affecting this Notice, a revised version of this Notice will be provided to you and all participants covered by the Plan at the time of the change. Any revised version of the Notice will be distributed within 60 days of the effective date of a material change to the uses and disclosures of PHI, your individual rights, the duties of the Plan or other privacy practices stated in this Notice. Material changes are changes to the uses and disclosures of PHI, an individual's rights, the duties of the Plan or other privacy practices stated in the Privacy Notice. Because our health plan does not post its Notice on a web site, we will provide the revised Notice, or information about the material change and how to obtain the revised Notice, to individuals covered by the Plan within 60 days of the material revision to the Notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services in accordance with their Enforcement activities under HIPAA,
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with the HIPAA privacy regulations.

This Notice does not apply to information that has been de-identified. De-Identified Information is information that does not identify you and there is no reasonable basis to believe that the Information can be used to identify you.

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary health Information means information that summarizes claims history, claims expenses or type of claims experienced by Individuals for whom the Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Plan's Privacy Officer, at the address listed on page 83. Neither your employer nor the Plan will retaliate against you for filing a complaint.

You may also file a complaint (within 180 days of the date you know or should have known about an act or omission) with the Secretary of the U.S. Department of Health and Human Services by contacting their nearest office as listed in your telephone directory or at this website http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html or this website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html or contact the Privacy Officer for more information about how to file a complaint. ·

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Plan's Privacy Officer at the address listed on page 83.

If you have any questions, please contact the Trust Fund Office at 775-826-7200 or Toll Free at (877) 826-5053.

Glossary of Terms used in this SPD

Accident (For purposes of accidental death and dismemberment Insurance). An event that was caused by a sudden, violent, and external force; was not expected and could not have been reasonably foreseen; could not have been avoided; and caused a physical injury.

Active Employee. An Employee who is not retired and who meets the eligibility provisions as a Collectively Bargained, Monthly Flat Rate, or Non-Collectively Bargained Employee, as defined in Chapter 2 of this document.

Allied Health Practitioner. A practitioner of the healing arts (behavioral health practitioner, a psychologist Ph.D., certified alcohol and drug abuse counselor CSAC, licensed clinical social worker LCSW, a marriage, family, and child counselor MFCC, chiropractor, nurse practitioner, physician assistant, podiatrist DPM, or occupational, physical, respiratory or speech therapist or speech pathologist, Registered Nurse First Assist RNFA, Certified Orthopedic Technician COT, Certified Surgical Assistant CSA only when assisting a Surgeon in lieu of an Assistant Surgeon, Doctor of Oriental Medicine OMD, an optometrist or an optician, a Pharmacist, or Dentist) who renders care or treatment within the limits set forth in the license issued to him/her by the applicable agency of the state in which he/she renders such care or treatment. The Allied Health Practitioner shall be reimbursed only for services covered by the Plan that would otherwise be covered if provided by a Physician.

Appropriate. A service or supply called for by the health status of a patient and likely to result in information that could affect the course of treatment (said of a diagnostic procedure) or produce a significant positive outcome (said of a care or treatment). In either case, the supply or service is considered no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

Allowed Charge means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. For Non-Contract Provider Emergency Services, non-Emergency Services provided by Non-Contract Providers at Contract facilities, and Non-Contract Air Ambulance services, the Allowed Charge is the Recognized Amount or the Out-Of-Network Rate when a claim is resolved by settlement agreement or IDR. For all other services, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the lowest of:

1. With respect to a PPO provider, the PPO Contracted Rate allowance; or

2. With respect to a Non-Network provider, the Allowed Charge amount means the Non-PPO Fee Schedule the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Contract providers. The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. or

3. For a PPO facility whose network contract stipulates that they do not have to accept the network Contracted fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the contracted fee/rate that would have been payable by the Plan had the claim been processed as a PPO claim; or

4. The provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket maximum. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Ancillary Services. The term "Ancillary services" means, with respect to a Contract health care facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

2. Items and services provided by assistant surgeons, hospitalists, and intensivists.

3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by a Non-Contract provider if there is no Contract provider who can furnish such item or service at such facility.

Behavioral Health Disorder. Behavioral Health is an umbrella term that refers to mental health and/or chemical dependence. A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental

Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document.

Board of Trustees. The Board of Trustees was established by the Trust Agreement. "Trustees" shall mean any person(s) designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such persons from time to time.

Chemical Dependency. This is another term for Substance Abuse/Substance Use Disorder. See also the definitions of Behavioral Health Disorders and Substance Abuse/Substance Use Disorder. See definition of "Behavioral Health Disorder" above.

Coinsurance. The arrangement by which you and the Fund each pay a percentage of Covered Expenses.

Continuing Care Patient: The term "Continuing Care Patient" means an individual who, with respect to a provider or facility-

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under section 186l(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Contract Rate. The negotiated fee/rate set forth in the agreement between the Fund and the provider (whether a Hospital, Physician, Allied Health Care Practitioner, or other health care provider).

Cosmetic Surgery or Treatment. Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-efficient. A medical service or supply that is no costlier than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

Covered Expense. Charges that are made for the Medically Necessary care of and treatment of an Illness or Injury that is covered under the Plan. The Covered Expense is the lowest of:

- The negotiated rate for services of a PPO Hospital or PPO Provider;
- The Scheduled Allowance for services of a Non-PPO Hospital or Non-PPO Provider;
- The Contracted Rate between the health care provider and a plan with which this Plan is coordinating benefits.

Custodial Care. Custodial care or rest cures; services provided by a rest home, a home for the aged, a nursing home, or any similar facility; or custodial hospital care is not a covered benefit.

Deductible. The number of eligible charges that each covered person must incur in each Calendar Year before benefits under the Plan will be paid. The deductible applies separately to each family member.

Deductible Carry-Over. If an eligible participant incurs charges during the last three (3) months of the calendar year that are applied towards satisfaction of but not satisfying the deductible, those charges will be applied toward that person's medical deductible for the next calendar year.

Dentist. A dentist is licensed to practice dentistry in the state in which he renders treatment.

Dependent Child(ren). See description in the Eligibility Chapter 2.

Drug. Any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a physician or dentist licensed by law.

Emergency Medical Condition. The term "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services. The term "Emergency Services" means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Contract provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and
- The participant or dependent gives informed consent to continued treatment by the Non-Contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

Essential Health Benefit. The term “Essential Health Benefit” means benefits that fall within the categories below as determined by the Plan and Claims Administrator in its sole discretion and subject to the requirements of the Affordable Care Act:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Maternity and newborn care.

(e) Mental Health and Substance Abuse Disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management.

(j) Pediatric services, including oral and vision care.

Experimental. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational or Unproven.

A service or supply will be deemed to be Experimental if, in the opinion of the Plan Administrator or its designee, any of the following was true regarding one or more essential provisions of the service or supply when it was provided or performed or

considered for Precertification under the Plan's Utilization Management program (based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for precertification):

- The prescribed service or supply could be given only with the approval of an Institutional Review Board as defined by Federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative peer-reviewed medical, dental or scientific literature on the subject, or a preponderance of authoritative medical or scientific Literature written by experts in the field and published in the United States showed that recognized medical or scientific experts classified the service or supply as experimental and/or investigational or indicated that more research was required before the service or supply could be classified as equally or more effective than conventional therapies (or there was an absence of authoritative medical or scientific literature on the subject).

  Authoritative peer-reviewed medical or scientific writings that will be considered include the "United States Pharmacopeia Dispensing Information"; "American Hospital Formulary Service"; publications of the American Medical Association (AMA); specialty organizations recognized by the AMA; the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Agency for Healthcare Research and Quality (AHRQ); other agency review organizations such as ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries; the American Dental Association (ADA), with respect to dental services or supplies; and the latest edition of "The Medicare National Coverage Determinations Manual;" Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- Food and Drug Administration (FDA) approval was required for the service and supply to be lawfully marketed, and it had not been granted at the time the service or supply was prescribed or provided, or a current investigational new drug or new device application had been submitted and filed with the FDA.

  (However, a drug will NOT be considered experimental and/or investigational if it has been approved by the FDA as an "investigational new drug for treatment use"; classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and prescribed for the treatment of a type of cancer for which it was not approved for general use, provided the FDA has not determined that such drug should not be prescribed for a given type of cancer.)

- The prescribed service or supply was available to the covered individual only through participation in Phase I or Phase II clinical trials or through Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

Family Unit. For purposes of the Hospice benefit, means the eligible members of the terminally ill Participant's immediate family.

Fund. The Northern Nevada Laborers Health and Welfare Trust Fund.

Gestational Surrogacy/Carrier. Gestational surrogacy is when the surrogate mother is not genetically related to the child. (Also see Surrogacy.)

Group Plan. Any plan providing benefits of the type provided by this Plan that is supported wholly or in part by employer payments.

Healthcare Facility. The term "Health Care Facility" (for non-emergency services) means each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(l) of the Social Security Act);
- An ambulatory surgical center described in section 1833(i)(l)(A) of the Social Security Act; and
- Any other facility, specified by the Secretary, who provides items or services for which coverage is provided under the plan or coverage, respectively.

Home Health Care Agency. An agency that meets all of the following requirements:

1. It provides skilled nursing services and other therapeutic services under the supervision of physicians and registered nurses.
2. It operates according to rules established by a group of professional medical people, including physicians and registered nurses.
3. It maintains clinical records on all patients.

4. It is licensed by the jurisdiction where it is located and operates according to the laws of that jurisdiction that pertain to agencies providing home health care.

Hospice Care. The treatment incurred during a period for which the Plan validates a Physician's certification as the Participant is terminally ill, and during the bereavement Period. "Terminally Ill" means that the patient has a life expectancy of six months or less.

Hospice or Hospice Agency. A facility or organization which administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care during the final stages of terminal illness and during bereavement. The facility or organization must be certified by the National Hospice Organization, Medicare, and local licensing organizations.

Hospital. Any acute care hospital that is licensed under any applicable state statute must provide 24-hour inpatient care and the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services. Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will not be regarded as a Hospital for any purpose related to this Plan.

Hour Bank. Established for an Employee to which are credited hours worked for Contributing Employers for which Contributions are made or are required to be made to the Fund on an Active Employee's behalf.

Illness. A bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes. The term "Illness" shall also include pregnancy.

Independent Dispute Resolution (IDR). Refers to a process used to resolve disputes between parties without the need for formal litigation or judicial intervention. It involves the appointment of an independent third party or neutral mediator who helps facilitate a resolution between the disputing parties.

Infertility. The inability to procreate due to physical or anatomical deficits of either partner such that an ovum cannot be impregnated or that once impregnated the fetus is not sufficiently viable to be carried to term, term being the development of the fetus so it can be self-sustaining outside of the uterus.

Injury. Physical harm sustained as the direct result of an accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Investigational. See "experimental."

Licensed Pharmacist. A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Local Union. Laborers Local Union No. 169, the Laborers International Union of North America, or Local Union No. 797, the Operative Plasterers and Cement Masons International.

Medical/Surgical Benefits. Is defined as medical or surgical benefits consistent with the most current version of generally recognized independent standards of current medical practice (ex. International Classification of Diseases).

Medically Necessary. A service or supply that is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it and is determined by the Plan Administrator or its designee to meet all of the following requirements:

1. It is consistent with the symptoms or diagnosis and treatment of the illness or injury,
2. It is not provided primarily for the convenience of the patient, physician, hospital or health care facility, or other health care provider,
3. It is an "appropriate" service or supply (see definition earlier in glossary), given the patient's circumstances and condition,
4. It is a "cost-efficient" supply or level of service (see definition earlier in glossary) that can be safely provided to the patient, and
5. It is safe and effective for the illness or injury for which it is used.

The fact that the physician or dentist may provide, order, recommend, or approve a service or supply does not mean that the service or supply will be considered medically necessary for the medical, dental, vision, or prescription drug coverage provided by the Plan. A hospitalization or confinement to a health care facility will NOT be considered medically necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated without the patient being confined. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or Health Care Facility or other costlier facility. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is Medically Necessary.

Medicare. The benefits provided under Title XVIII of the Social Security Amendments of 1965.

Mental Health; Mental Disorder; Mental and Nervous Disorder. See the definition of Behavioral Health Disorder.

Non-Contract Emergency Facility. The term "Non-Contract emergency facility" means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship with Northern Nevada Laborers Health and Welfare trust Fund, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-Contract Hospital. A hospital that does not have a contract in effect with the Fund under the Preferred Provider Organization (PPO).

Non-Contract provider. Any Physician or Allied Health Practitioner, laboratory or radiology facility, free-standing surgical facility or provider of durable medical equipment that does not have a contract in effect with the Fund under the Preferred Provider Organization (PPO). Non-Contract Provider shall also include an ophthalmologist, optometrist, or optician with whom does not have a contract in effect with the Fund with respect to services covered under the Vision Care Benefits. Contract Provider shall also include a Dentist who does not have a contract in effect with the Fund with respect to services covered under the Dental Benefits.

Non-Essential Health Benefits. The term "Non-Essential Health Benefits" means benefits that are NOT essential health benefits as determined by the Plan and Claims Administrator in its sole discretion. The Board of Trustees is authorized to establish limits on non-essential health benefits provided under the Plan consistent with the Affordable Care Act and lawful regulations issued thereunder.

Non-PPO Scheduled Fee Schedule. See Allowed Charge.

No Surprises Act. The term "No Surprises Act" means the federal No Surprises Act (Public Law 116-260, Division BB).

Out-of-Network Rate. The term "Out-of-Network Rate" with respect to non-emergency items and services furnished by a Non-Contract provider at a Contract Facility, Non-Contract Provider emergency facility, or Non-Contract provider of air ambulance services, means one of the following:

- The amount the Fund and Non-Contract Provider agree upon, provided that, if the settled Claim is covered by the No Surprises Act the settlement does not result in higher participant or dependent Cost sharing than is permitted under the No Surprises Act.
- The amount the parties agree upon during the open negotiations period under the No Surprises Act.
- The amount of the offer selected by the independent dispute resolution (IDR) entity under the No Surprises Act; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system. The Fund is administered and domiciled in Nevada and Nevada does not have an All- Payer Model Agreement.

Observation Short Stay. The documented assignment of a patient to a hospital bed for diagnostic watching or observation during which time the patient does not receive any therapeutic or surgical intervention. When any observation short stay patient remains in a hospital bed after the hour of midnight, the observation short stay is considered an inpatient stay, and the Hospital shall be reimbursed at the appropriate inpatient rate for all services rendered after the hour of midnight for this type of inpatient confinement. All of the following days will also be considered at the appropriate patient rate.

Participant. Each eligible Active Employee, Retirees, and each of their Dependents.

Patient. The eligible individual who is receiving medical treatment, services, or supplies covered by the Plan.

Physician. A physician or surgeon (M.D. or D.O.), or a dentist (D.D.S. or D.MD.) licensed to practice in the state in which he or she practices.

Plan. The "Plan" means the Rules and Regulations of the Direct Payment Plan and any amendments to it.

Plan Administrator. The Board of Trustees of the Northern Nevada Laborers Health and Welfare Trust Fund has been designated as the Plan administrator by the Plan Sponsor and has the responsibility for overall Plan Administration.

Plan Year. The twelve-month period from September 1 to August 31 is designated to be the Plan Year.

PPO Hospital. A hospital that has a contract in effect with the Fund under the Preferred Provider Plan.

PPO Provider. A Physician or Allied Health Practitioner, laboratory or radiology facility, free-standing surgical facility or provider of durable medical equipment that has a contract in effect with the Fund under the Preferred Provider Plan. PPO Provider shall also include an ophthalmologist, optometrist or optician with a contract in effect with the Fund with respect to services covered under the Vision Care Benefits. PPO Provider shall also include a Dentist who has a contract in effect with the Fund with respect to services covered under the Dental Benefits.

Preferred Provider Organization. A program whereby hospitals, laboratory/radiology facilities, and physicians and Allied Health

Practitioners and other health care facilities contract with the Fund to provide necessary hospitalization and medical services to eligible individuals at a negotiated rate, approved by the Board and amended from time to time.

Pregnancy. Pregnancy is the condition of carrying a developing embryo in the uterus of an eligible Participant and/or dependent spouse. Voluntary termination of pregnancy for an eligible Participant and/or dependent spouse is covered and limited to one per Participant and/or dependent spouse per lifetime. Complications of pregnancy will be considered as any other illness. There is no coverage for surrogate/gestational carrier pregnancies, including complications thereof. Pregnancy of a dependent child is not covered.

Prescription Drug. Any article which may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a licensed Physician or Dentist.

Reciprocity Agreement. The agreement that establishes the administrative procedures for reciprocity between funds, and any modification, amendment, extension, or renewal thereof.

Reserve Account. The account established for an Active Employee to which are credited all hours worked for Contributing Employers for which Contributions are made or required to be made to the Fund on an Active Employee's behalf.

Retired Employee. A person who meets the eligibility requirements in Retired Employee Eligibility section in Chapter 2 of this document.

Spouse. An employee's or retiree's Spouse means a person of the opposite gender or same gender who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union partner, a divorced former Spouse of an employee or retiree, or a spouse of a Dependent Child. An ex-spouse is not eligible even if an employee or retiree is required by a divorce decree, court order or other legal action to continue coverage for the ex-spouse.

Surrogacy. Traditional surrogacy is when the surrogate mother is artificially inseminated with the sperm of the intended father or sperm donor. The surrogate's own egg will be used; thus, she will be the genetic mother of the resulting child. Gestational surrogacy is when the surrogate mother is not genetically related to the child. Eggs are extracted from the intended mother or egg donor and mixed with sperm from the intended father or sperm donor in vitro. The embryos are then transferred into the surrogate's uterus. Embryos which are not transferred may be frozen and used for transfer at a later time if the transfer does not result in pregnancy.

Surrogate. One that takes the place of another, a substitute. A surrogate mother.

Surrogate Mother. A woman who carries and gives birth to the child of another woman, who is usually infertile, by the way of a pre-arranged legal contract.

Scheduled Allowance/Schedule of Allowances. The dollar amount the Plan has determined will allow for an eligible Medically Necessary service or supply performed by Non-Network providers. The description of covered benefits payable under the Plan and the amount payable for such benefits, as approved by the Board and amended from time to time, are collectively referred to as the Schedule of Allowances. The schedule of allowances provides specific reimbursement levels depending on whether benefits are due for services received from a PPO Hospital or PPO Provider, or a Non-PPO Hospital or Non-PPO Provider.

Terminally Ill. The patient has a life expectancy of six months or less.

Totally Disabled. Unable, due to illness, disease, injury, or pregnancy, to perform substantially all of the material duties of the occupation in which you were engaged prior to disability and not engaged in any gainful occupation. For purposes of extended employee life insurance coverage, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. This includes:

- **Autologous** transplants of organs, tissues or cells from one part of the body to another. Bone marrow, peripheral stem cells and skin transplants are often autologous.
- **Allogenic** transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan, except as determined to be an FDA-approved use of xenographic tissue such as a porcine heart valve.

Trust Agreement. The Trust Agreement establishing the Northern Nevada Laborers Health and Welfare Trust Fund and any modification, amendment, extension, or renewal thereof.

Utilization Review (UR) Program. A program whereby the Fund determines the medical necessity of services and supplies. The UR representative also handles urgent care claims for medical care and confirms whether a hospital, physician, or other health care provider is a PPO Provider. A program whereby a Participant who is scheduled for an elective, non-emergency Hospital confinement must obtain review by the Fund to determine the Medical Necessity of such confinement and the length of stay for the

purpose of unreduced benefit coverage under the Plan. For emergency confinements, such review must be obtained retrospectively.

Well Child Care. Services up to Age 19. Includes immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.