ELECTRICAL WORKERS HEALTH AND WELFARE PLAN FOR NORTHERN NEVADA

SUMMARY PLAN DESCRIPTION and PLAN DOCUMENT

(ACTIVE EMPLOYEES)

Providing Comprehensive Medical, Prescription Drug, Vision and Dental Benefits, (and Life Insurance and Accidental Death & Dismemberment Benefits)

Restated March 1, 2021

Keep this Summary Plan Description For Future Reference

Trust Fund Office Address: 445 Apple Street, P.O. Box 11337 Reno, Nevada 89510
T: (775) 826-7200 (Website: *ewtrust.com*)
Union Office Address: IBEW Local 401 4635 Longley Lane, Suite 109 Reno, Nevada 89502
T: (775) 329-7174 (Website: *http://www.ibew401.com/*)

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Dear Participant & Dependent:

The Board of Trustees is pleased to provide you this new Restated booklet. This booklet is both the Plan document and Summary Plan Description for the Electrical Workers Health and Welfare Plan for Northern Nevada ("Plan"). The first part of the booklet contains general information regarding your medical and related benefits and an explanation of the eligibility provisions for both active and certain retired Participants. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Fund Office at the above address.

The Plan's Medical, Prescription Drug, Vision, and Dental benefits are self-funded (meaning the benefits are not insured by any contract of insurance or other arrangement). There is no liability on the part of the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Trust Fund collected and available for such purpose.

This booklet also contains information about Life Insurance and Accidental Death and Dismemberment benefits.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, Employer, Fund Office, or Union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board unless the Board has delegated that authority. The Board also has discretion to make any factual determinations concerning your claim.

As a courtesy to you, the Trust Fund Office may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits provided under the Plan (or any insurance policy or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.

Sincerely,

Board of Trustees

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IMPORTANT NOTICES

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. You will be notified in writing if there are important amendments to the Plan. Before you decide to retire, you may want to contact the Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement Plans. This Plan provides only limited retiree medical benefits in any event.

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 not entitled to rely upon oral statements of 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. **The Board of Trustees reserves the right to make corrections whenever any error and/or overpayment is discovered**.

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. Thus, there is no guaranteed right to receive Plan benefits. The Board of Trustees may amend or otherwise change the Plan at any time including reducing or discontinuing certain or all benefits. Moreover, the Board of Trustees may require new or greater co-payments or other Employee contributions at any time. The Board of Trustees may change the eligibility requirements and any other Plan rules at any time.

I. INTRODCUTION

The Board of Trustees is pleased to issue this new Restated Plan Booklet, effective January 1, 2021, including all prior amendments. This Booklet serves as the Summary Plan Description and Plan Document for the **Electrical Workers Health and Welfare Plan for Northern Nevada ("Plan")**. The Plan includes Medical, Prescription Drug, Vision, Dental, and Chemical Dependency benefits through a Self-Funded Trust. Insured Life Insurance and Accidental Death and Dismemberment Insurance are also provided. The provisions of the Sound and Communication Workers Plan are the same as these provisions except where noted.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, Employer, or Union representative has authority to interpret this Plan on behalf of the Board. The Board also has discretion to make any factual determinations concerning your claim.

The Trust Fund Office may respond in writing to your written questions. If you have an important question about your benefits, you should write to the Trust Fund Office at the above address. As a courtesy to you, the Trust Fund Office may respond informally to oral questions; **however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.**

Plan rules and benefits may change from time to time. Your benefits under the Plan are NOT vested. The Board of Trustees may reduce, eliminate or change any benefit provided under the Plan (or any insurance policy, HMO or other entity) at any time. Participants may also be required to make new or additional contributions for benefits provided by the Plan.

Several cost saving features are available for your use. Included among these are networks of physicians, hospitals, laboratories and pharmacies. **Failure to use these network providers will result in significantly higher charges to you and the Trust.** If you are contemplating a surgical procedure or a series of medical treatments and you have questions regarding the amount of coverage available under this Plan, you should contact the contact the Trust Fund Office.

Prescription drugs have become an increasingly higher percentage of the total medical care costs incurred by your Plan. The Trustees have attempted to help reduce these costs, while maintaining the current level of benefits, by contracting with a Pharmacy Benefit Manager. **Additional savings may be realized by the use of generic drugs rather than name brands. If you do not show your pharmacy your Optum RX card, your benefit will be reduced to the reduced allowable Plan amount.** You are urged to discuss with your physician the possibility of using generic drugs if you are not already utilizing them.

II. IMPORTANT INFORMATION

A. MEDICALLY NECESSARY. The Plan only recognizes charges for services and supplies which are "Medically Necessary" or provided due to Medical Necessity if the service and supply is determined by the Plan to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of an illness, injury or condition; and

2. Not experimental, educational or investigation; and

3. Not primarily for your convenience or the convenience of your physician or other provider; and

4. Within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in Nevada; and

5. The most appropriate supply or level of service which can safely be provided; and

6. When applied to hospitalization, the symptoms or condition cannot safely and adequately be treated on an outpatient basis; and

7. The fact that a physician or other medical provider may prescribe, order, recommend or approve a service does not of itself make such a service or supply Medically Necessary, even though it is not specifically listed as an exclusion.

B. <u>COVERED EXPENSES AS MEDICALLY NECESSARY:</u>

THE USE OF THE CONTRACT HOSPITALS, CONTRACT DOCTORS AND PREFERRED PROVIDERS WILL REDUCE YOUR OUT-OF-POCKET EXPENSES. THE FOLLOWING EXPENSES ARE COVERED BY THE PLAN IF MEDICALLY NECESSARY:

1. Semi-private hospital room and board
2. Intensive care unit
3. Inpatient hospital miscellaneous
4. Convalescent care facility /Skilled nursing facility
5. Inpatient alcoholism/drug abuse treatment
6. Hospital outpatient emergency room
7. Surgery
8. Anesthesia
9. Non-custodial home health care
10. Doctor visits –office or hospital
11. Radiation therapy
12. X-rays and diagnostic imagery
13. Diagnostic lab tests
14. Treatment of vertebrae, spine, back or neck (maximum 15 visits per calendar year)
15. Acupuncture (limited to 15 visits per calendar year)
16. Physical therapy
17. Nursing services
18. Ambulance service
19. Appliances/durable medical equipment
20. Prescription drugs
21. Hospice Care
22. Preventive care benefits including Well Child Care
23. Bariatric Surgery
24. Mental health disorders
25. Hearing Aids

26. Temporal Mandibular Joint Syndrome (TMJ)

C. <u>TO AVOID DENIAL OF COVERAGE, REVIEW THE FOLLOWING:</u>

1. Read the Eligibility Rules and if you are not certain that you or your dependents are eligible, contact the Trust Fund Office (see Article VI).

2. Before you are admitted to the hospital, see the information regarding Contract Providers and the requirements for Prior Authorization/Utilization Review as outlined in Article IV.

3. If you are not eligible through hours contributed by an Employer, you may qualify for continued coverage under COBRA. Be certain to read this procedure in Article X.

4. Although most illnesses are covered, if you are in doubt, contact the Trust Fund Office after you have reviewed "General Exclusions, Limitations and Reductions" in Article XVII.

5. It is important that you complete and sign your claim form as described in Article XX, Sections C, D, E and F.

6. In the event of a divorce, your spouse's coverage will terminate when your divorce decree is final. (See Article X for COBRA continuation of benefits information). You should notify the Trust Fund Office immediately regarding any change in marital status.

7. See Article XXIX for an explanation of your rights under ERISA.

8. In the event a claim is denied, the Appeal Procedure is set forth in Article XXIII.

D. <u>CONTRACT FEE SCHEDULE</u>. The Rules and Regulations utilize a Contract Fee Schedule also known as the Schedule of Allowances for the non-PPO claims and services. As for the PPO claims and services, the Plan uses the negotiated Contract Rate. **Thus, the Plan does not use "Usual Customary and Reasonable", "Reasonable and Customary" or "Billed Charges".**

E. <u>SPECIFIC EXCLUSIONS</u>. The Plan lists several types of medical procedures, supplies and other charges which are <u>not</u> covered by the Plan. The specific exclusions are listed on pages 36-39 of this booklet. Exclusions for your Prescription Drug Coverage are listed on Pages 47-48, for vision care on page 49, and dental benefits on pages 53-55.

D. <u>TRUST FUND OFFICE NEEDS YOUR CURRENT ADDRESS</u>. When the Fund Office is informed that you or a dependent's coverage is going to terminate, it is required by law to send you information about your right to make self-payments. Therefore, you should always provide the Fund Office with the current mailing address including your phone number and e-mail address for you and your eligible dependents so that this information as well as other important notices can be provided to you.

E. <u>PRONOUNS USED IN THIS BOOKLET</u>. Wherever the term "you" or "your" is used in this booklet, it means an eligible employee or, where applicable, an eligible retiree. And, to avoid awkward wording, male personal pronouns are used to refer to employees and retirees. Feminine pronouns are used when referring to spouses. When a personal pronoun is used in the masculine gender, it shall be deemed to include the female also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine.

III. SCHEDULE OF MEDICAL BENEFITS

BENEFITS (Plan Pays)	PPO (Preferred Provider Organization)		NON-PPO (Preferred Provider Organization)	
	All Employees Except Sound & Comm. Workers	Sound & Comm. Workers	All Employees Except Sound & Comm. Workers	Sound & Comm. Workers
LIFETIME MAXIMUM ANNUAL LIMIT	**None.**	**None.**	**None.**	**None.**
OUT OF POCKET LIMIT	$1,000 Individual limit plus cost of non-covered charges.	$2,000 Individual limit plus cost of non-covered charges.	$1,000 Individual limit plus cost of non-covered charges and amount over Non-PPO.	$2,000 Individual limit plus cost of non-covered charges and amount over Non-PPO.
STOP LOSS COVERED CHARGES	$5,000 Stop loss afterwards 100% of Schedule Allowance.	$10,000 Stop loss afterwards 100% of Schedule Allowance.	$5,000 Stop loss afterwards 100% of fee schedule plus amount over Non-PPO.	$10,000 Stop loss afterwards 100% of Schedule Allowance plus amount over Non-PPO.
ANNUAL DEDUCTIBLE AMOUNT INCLUDES DEDUCTIBLE CARRY-OVER	$200 Individual/ $400 Family	$300 Individual/ $600 Family	$200 Individual/ $400 Family	$300 Individual/ $600 Family
PERCENTAGE PAYABLE	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% to 80% Schedule Allowance.
HOSPITAL STAY (Prior Authorization Required.)	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
MEDICAL BENEFITS				
Doctor's Visit	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Specialist Visit	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Outpatient Surgery (Facility). (Prior Authorization Required).	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
PREVENTIVE CARE BENEFITS (Routine Physical Exam is limited to One exam/visit, One basic x-ray, and 10 basic laboratory per calendar year.)				
Routine Preventive Care (Adult)	80% of Schedule Allowance. **(No Deductible)**	80% of Schedule Allowance. **(No Deductible)**	80% of Schedule Allowance. **(No Deductible)**	70% of Schedule Allowance. **(No Deductible)**
OB/GYN	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Colonoscopy (Every 5 years for ages 50 and older Participant.)	80% of Schedule Allowance. (Deductible Applies)	80% of Schedule Allowance. (Deductible Applies)	80% of Schedule Allowance.	70% of Schedule Allowance.
Coronary Calcium Scoring CT Scan	80% of schedule Allowance (**No Deductible**)	80% of Schedule Allowance (**No Deductible)**	80% of Schedule Allowance	80% of Schedule Allowance

Well Child Preventive Care – Up to Age 19 (Deductible Applies. (includes routine diagnostic testing or routine childhood vaccinations up to age 19 in accordance with Recommendations for Preventive Pediatric Health Care by American Academy of Pediatrics))	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% or 80% of Schedule Allowance.
Diagnostic test (x-rays, blood work, lab work not received at LabCorp & Quest.)	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Labwork at Lab Corp or Quest and Renown Medical Center	100% of Schedule Allowance. **(No Deductible)**	100% of Schedule Allowance. **(No Deductible)**	80% of Schedule Allowance.	70% of Schedule Allowance.
Imaging (CT/PET scans, MRIs)	80% of Schedule Allowance.	80% of contract rate.	80% of Schedule Allowance.	70% of Schedule Allowance.
MATERNITY CARE (Employee, Dependent Daughter and Spouse Coverage).				
Prenatal and Post Natal Care	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Delivery and Inpatient Services	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.

BENEFITS (Plan Pays)	**PPO (Preferred Provider Organization)**		**NON-PPO (Preferred Provider Organization)**	
	All Employees Except Sound & Comm. Workers	**Sound & Comm. Workers**	**All Employees Except Sound & Comm. Workers**	**Sound & Comm. Workers**
MENTAL/NERVOUS DISORDER TREATMENT				
Inpatient Treatment (Must be pre-authorized, prior to confinement.	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.
Outpatient Treatment	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.
ALCOHOL/SUBSTANCE ABUSE TREATMENT (This Plan includes a preferred provider arrangement and treatment preauthorization as cost control features for alcohol and substance abuse treatment. See Article XIV of the Comprehensive Medical Benefits.)				
Inpatient Treatment (Must be pre-authorized prior to confinement.)	75% of Schedule Allowance	75% of Schedule Allowance.	75% of Schedule Allowance.	75% of Schedule Allowance.
Outpatient Treatment	75% of Schedule Allowance.	75% of Schedule Allowance.	75% of Schedule Allowance.	75% of Schedule Allowance.
EMERGENCY MEDICAL ATTENTION				
Emergency Room Services	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
Ambulance	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance	70% of Schedule Allowance.
Urgent Care	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.
OTHER BENEFITS				
Skilled Nursing Care (Limited to 100 days per confinement. Successive periods of confinement must be separated by 30 days.)	80% of Schedule Allowance.	80% of Schedule Allowance.	80% of Schedule Allowance.	70% of Schedule Allowance.

Physical Therapy (Doctor's orders required)	80% of Schedule Allowance.	80% of Schedule Allowance.	50% of Schedule Allowance.	50% of Schedule Allowance.
Hospice Service No Deductible.)	100% of Schedule Allowance.	100% of Schedule Allowance.	100% of Schedule Allowance.	70% of Schedule Allowance.
Supplemental Accident Expense Benefit	100% of first $300 if treatment received within 72 hours of the accidental injury.			
Hearing Aids	Limited to $5,000 per hearing device or per pair ($2,500 each ear) every 3 years.			
Bariatric Surgery	Up to (1) Surgery Per Year. Prior Authorized.			
Temporomandibular Joint Disorder	Up to (1) Treatment Per year			

LIFE and AD&D INSURANCE BENEFITS	**PLAN PAYS**
Life Insurance Coverage	$5,000 (Active Employees Only).
Accidental Death & Dismemberment Coverage (AD&D)	$5,000 (Active Employees Only).

DENTAL BENEFITS	**Contract Provider**	**Non-Contract Provider**
DENTAL BENEFITS – No Dental Deductible		
Percentage payable for covered charges:	90% of contract rate	80% of non-PPO fee schedule
Calendar Year Maximum	$2,500 Per Adult. No limit for Dependent Child under Age 19	
ORTHODONTIC BENEFITS		
Percentage payable for covered charges:	80% of contract rate	80% of non-PPO fee schedule
Lifetime Maximum	$1,500 Per Adult. $2,500 Per Dependent Child.	

VISION CARE BENEFITS **Lenses & Exam – Every 12 months** **Contacts & Frames – Every 12 months**	**Contract Provider**	**Non-Contract Provider**
Coverage (Adult)	Paid at 100% of negotiated fees	Up to Schedule of Allowance **(See Article XII.)**
Coverage (Children up to Age 19)	Paid at 100% of negotiated fees	100% of fee schedule

PRESCRIPTION DRUGS BENEFIT%S (through OPTUM RX)	**Contract Provider**		**Non-Contract Provider**	
Deductible does NOT apply to Mail Order. Covers up to 90 Day Supply except for insulin & diabetic drugs.	**All Employees Except Sound &Comm. Workers**	**Sound& Comm. Workers**	**All Employees Except Sound& Comm. Workers**	**Sound& Comm. Workers**
• **Generic Drugs**	20% coinsurance (retail) & $40 or cost whichever less (mail)	20% coinsurance (retail) & $40 or cost whichever less (mail)	20% coinsurance up to network allowable amount plus any charges above (retail); Not Covered (mail)	30% coinsurance up to network allowable amount plus any charges above (retail); Not Covered (mail)
• **Preferred Brand Drugs** • **Non-Preferred Brand Drugs** • **Specialty Drugs** (Pre Auth. Required).	20% coinsurance (retail) & $80 or cost whichever less (mail)	20% coinsurance (retail) & $80 or cost whichever less (mail)		

REMINDER- AS A PARTICIPANT IT IS YOUR RESPONSIBILITY TO:

- **Follow the cost containment requirements for emergency room services and for non-emergency hospital stays.**
- **Before making an appointment with a provider you have not seen before or to determine if a provider is a current "contracted PPO provider" you should contact the Health Care Service department at (775) 826-7200.**
- **Notify the Trust Fund Office of changes in dependent spouse and/or child(ren) eligibility. You will be required to reimburse the Plan for non-eligible participant benefit payments and any payment made on your behalf for non-eligible dependents.**
- **Notify the Eligibility Department at the Trust Fund Office of any changes in your home address or contact information (including phone number and e-mail)**
- **Notify the Trust Fund Office if you have coverage with another group health plan or other insurance in addition to coverage under this Plan.**
- **Notify the Trust Fund Office no later than 60 days from the date of a qualifying event (such as termination of employment, reduction of hours, divorce or legal separation, entitlement to Medicare, and cessation of dependent child(ren)'s status) for COBRA coverage.**
- **Notify the Trust Fund Office if any medical claims incurred under the Plan, by you and/or your dependent(s) are the result of an accident, injury, disease, or other condition for which a third party is or may be liable for.**
- **Properly complete and timely submit once a year a Claim Form to the Trust Fund Office for each family member under the Plan.**
- **When a claim is processed, you and the Provider of service will receive an Explanation of Benefits (EOB). Keep all of the EOBs that you receive. You may need them. The Trust Fund Office is no longer able to reprint them for you.**
- **Notify the Trust Fund Office in advance of any non-emergency hospital confinement.**
- **When information is requested, please promptly respond within the time period required by the Plan.**
- **When you receive any letters from the Trust Fund Office requesting information, you must complete them and return the information to the Trust Fund Office as soon as possible. There is a 180-day limit for information to be returned back to the Trust Fund Office. Failure to do so will result in the denial of you or your Dependents claims.**

DEATH BENEFITS

A. BENEFITS

The amount of the death benefit is shown below. **Death Benefits are for Active Participants only. No death benefits are paid for retirees or for the death of your spouse, children or other dependents. The amount that will be paid to your beneficiary in the event of your death from any cause on or off the job while covered is:**

Category	Death Benefit
Active Employees	$5,000

The same $5,000 is paid for an **Accidental Death and Dismemberment benefit, which is paid for the**

loss of:

Life	**Quadriplegia**
Both hands and both feet	**One hand and sight of one eye**
One foot and sight of one eye	**One hand and one foot**

Loss of sight means total and irrecoverable loss of sight of that eye. Loss of hands or feet means severance of the entire hand or foot at or above the wrist or ankle joint.
The death benefit is payable to your beneficiary. The dismemberment or loss of sight benefit is payable to you in the manner described above.

B. BENEFICIARY

Your beneficiary may be any person or persons you name. You may change your beneficiary at any time by making a written request upon a form available at the Trust Fund Office. A change of beneficiary form must be received by the Trust Fund Office before your death to be effective.

If you do not name a beneficiary, benefits will be paid as follows:

1. To your surviving spouse (gets everything);
2. If you have no surviving spouse, in equal shares to your natural or legally adopted children (not stepchildren);
3. If you have no surviving spouse and no surviving children, in equal shares to your parents (or surviving parent gets everything);
4. If you have no surviving spouse, no surviving children and no surviving parents, in equal shares to your siblings (or surviving sibling gets everything); and
5. If you have no surviving spouse, no surviving children, no surviving parents and no surviving siblings, benefits would be paid to your estate.

C. EXCLUSIONS: DEATH/ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Payment for all losses due to any one accident may not exceed the full amount of your benefit. **The Plan provides that no benefits are payable for any loss resulting from:**

1. Disease, bodily or mental infirmity or medical or surgical treatment of these: or intentionally self-inflicted injuries, suicide or attempted suicide, while sane unless the injury resulted from an act of domestic violence or a medical condition such as depression.
2. War or any act of war whether or not declared, or service in the armed forces of any country engaged in war or police duty.
3. Participation in a riot or insurrection, or commission of an assault or a felony (no criminal charge or conviction is required).
4. Driving while intoxicated, as defined by the applicable state law where the loss occurred.
5. Disease.
6. Injury sustained in the course of any medical, dental or surgical diagnosis or treatment.

IV. YOUR PLAN BENEFITS

A. ENROLLMENT PROCEDURE

It is important that the Trust Fund Office has a completed Enrollment Form for you in its files. It is necessary

that you complete an Enrollment Form before any claim can be processed. If you have not completed an Enrollment Form or if an additional card is needed, you may obtain one from your Local Union Office or from the Trust Fund Office. You can also visit the Plan website to obtain an Enrollment Form.

The Enrollment Form is the means by which an Employee designated Dependents, as well as the beneficiary for Life Insurance and Accidental Death Dismemberment benefits.

New Participants must also submit: 1) a copy of your certified marriage certificate to enroll their lawful spouse, 2) a birth certificate (or adoption papers or court order)for each eligible Dependent Child, and 3) Copies of your Social Security Card for each enrollee. Additional documentation may be required to enroll stepchildren or foster children; contact the Trust Fund Office for additional information.

It is important that you notify the Trust Fund Office in the event that:

1. You change your home address.
2. You wish to change your beneficiary.
3. There is any change in your family status, *i.e.*, marriage, birth of a child, adoption, death, divorce or legal separation, etc.

IMPORTANT: <u>You can be held liable for benefit payments issued based on any incorrect and/or false information about your family members, such as failing to notify the Trust Fund Office of a divorce, if your child reaches age 26, or if an adoption is rescinded. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect and/or false information. These costs include, but are not limited to, attorney's fees, Trust Fund Office costs, other administrative costs, and reasonable interest.</u>

B. <u>HOW TO FILE YOUR CLAIMS</u>

1. <u>Obtain a Claim Form</u>. Obtain a claim form from the Trust Fund Office at 445 Apple Street, Reno, Nevada 89502 (775-826-7200).

2. <u>Sign and Complete Form</u>. Complete and sign Part I of the Claim Form (the Employee's signature is required for Part I). Your Physician or Allied Health Professional may complete Part II, or you may attach an itemized bill to the Claim Form. The Plan requires that a minimum of one completed Claim Form be submitted each year for each Participant. You must use a separate Claim Form for each Participant. You can obtain a Claim form by contacting the Trust Fund Office.

<u>ALERT—ONE YEAR TO FILE CLAIMS</u>

Notice of a Medical, Dental or Vision claim must be filed with the Trust Fund Office within 1 year from the date on which covered expenses were incurred, unless it is not reasonably possible to give notice within this time. The Trustees have absolute discretion to make this determination. In no event or benefits paid if notice of claim is made beyond 1 year from the date on which covered expenses were incurred.

<u>REMEMBER</u>: Completed Claim Forms with all required signatures will ensure your claim being processed at the earliest possible date. If, after you have filed a completed Claim Form, you receive other itemized bills for the same Illness or Injury, mail them to the Trust Fund Office. You do not need a new Claim Form as long as these itemized bills are for your existing claim.

3. Be sure your bills are itemized. The following information must be indicated on the bills or Claim Form submitted:

- Employee's name
- Employee's social security number or Member ID#
- Patient's name and address
- Patient's birth date and relationship to Employee
- If treatment is related to Injury, date and place of injury, including details (i.e., automobile accident, fall, etc.)
- Name of physician who ordered service and reason for service (diagnosis)
- Date each service was performed, and cost for each service
- Complete description of each service

Amounts payable for Life Insurance and/or Accidental Death and Dismemberment Benefits will be paid to the designated beneficiary. All other Benefits will be paid by the Fund to the Employee, unless payment has been assigned to the provider. After your claim has been processed, you will receive an *Explanation of Benefits Form* which gives you information about the status of your claim and any deductible remaining for the current year.

The *Explanation of Benefits Form* will also inform you if the Trust Fund Office needs additional information to complete the processing of your claim. The Fund has the right to obtain information necessary to evaluate claims and may release such information as may be necessary to its consultants, attorneys, or other persons ore organizations.

Advise the Trust Fund Office if you have other insurance. If the other coverage terminates, provide the Trust Fund **Office with the date of termination. If you don't notify the** Trust Fund **Office of other insurance, it will be unable to coordinate the benefits and this could result in an overpayment on your claim which must be repaid to the fund.**

Benefits are payable according to the discounted fees and Schedule of Allowance; however, benefits are not payable under this Plan for expenses incurred which are not Medically Necessary, or which are in excess of the Schedule of Allowance as determined by the Board of Trustees.

The Fund, at its own expense, has the right to have a Physician of its choice examine a Participant or beneficiary when and so often as the Fund may require during the pendency of any claim and, in the case of death, may make an autopsy where it is not forbidden by law.

Under no circumstances is the Fund liable for the negligence, wrongful acts or omissions of any doctor, dentist, laboratory or other person or organization performing services or supplying materials in connection with benefits under this Plan.

C. METHOD/FACILITY OF PAYMENT

Except as specifically provided below, each Participant or beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any Benefit payable or any other right or interest under the Plan. The Fund is not required to recognize any such sale, transfer anticipation, assignment, alienation, hypothecation or other disposition. Any Benefit, right or interest is not subject in any manner to voluntary transfer by operation of law or otherwise and is exempt from the claims of creditors or other

claimants and from all order, decrees, garnishments, executions or other legal process or proceedings to the fullest extent permitted by federal law.

Any Participant or beneficiary may direct that Benefits be paid to a provider of covered health services or supplies in consideration for services rendered or supplies furnished, or to any other agency that may have provided or paid for any Benefits provided under the Plan.

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

D. DISCLOSURE STATEMENT-GRANDFATHERED PLAN

The Board of Trustees believes that the health 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 does not have to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime and annual 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 Fund Manager at (775) 826-7200. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

This ends the Summary portion of the Plan booklet. The formal Plan document begins on the next page.

ARTICLE V. ESTABLISHMENT AND OPERATION OF THE PLAN

A. ESTABLISHMENT OF PLAN

1. **Restatement of Plan**. The Board of Trustees of the Electrical Workers Health and Welfare Trust for Northern Nevada restates the Electrical Workers Health and Welfare Plan for Northern Nevada Plan ("Plan") by this Plan Document effective as of January 1, 2021.

The Plan is intended to be maintained for the exclusive benefit of Participants and their beneficiaries. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

2. **May offer Benefits Through Insurance Company**. The Board of Trustees may self-fund certain or all Plan benefits or it may from time to time offer to eligible Employees and dependents the option to elect enrollment through an insurance contract.

B. PLAN MAY BE CHANGED

The Board of Trustees of the Plan expressly reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. Benefits provided under this Plan are **not** vested. The Board of Trustees expressly reserves the right, in its sole discretion, to:

1. 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. alter or postpone the method of payment of any benefit; and
3. amend, terminate or rescind any provision of the Plan; and
4. merge the Plan with other Plans, including the transfer of assets; and
5. terminate insurance company; and
6. restrict coverage to those living only in certain geographic areas.

The authority to make any such changes to the Plan rests solely with the Board of Trustees. Any such amendment, modification, revocation or termination of the benefit or rule shall be made by a motion adopted by the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

C. ADMINISTRATION AND OPERATION

1. **Board of Trustees Responsibilities**: The Plan is administered by a Board of Trustees comprised of up to eight Trustees. One-half of the Trustees, called "Employer Trustees," are selected NECA, Greater Sacramento Area Chapter, Reno Division that is signatory to a Collective Bargaining Agreement with IBEW Local 401 and one-half of the Trustees, called "Union Trustees," are selected by IBEW Local 401. The current Trustees are listed on page ii of this booklet.

The Board of Trustees has many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, deciding policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel and benefit consultant.

Only the Board of Trustees, and its authorized representatives, is authorized to interpret the Plan schedule of benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, Employer Associations, the Union and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Trustees. Plan definitions are in Article V beginning on page 40.

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretations, computations and actions of the Board shall be binding and conclusive on all persons.

2. **Standards of Interpretation**: The Board of Trustees, and/or persons designated by the Board, such as the Chair and Co-Chair of the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind the Trustees to an interpretation of the provisions of this Plan.

3. **Delegation of Duties and Responsibilities**: The Board of Trustees may engage such Employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or other persons to render advice and/or to perform services with regard to any of its responsibilities under the Plan, as it shall determine to be necessary or appropriate.

4. **Employer Contributions**: Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with IBEW Local 401. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. The Employer's hourly contribution rate is subject to change at any time if agreed to by the bargaining parties. The bargaining parties also may allocate additional or different contribution amounts to help fund the Plan.

Your Employer is required to make monthly contributions for your Covered Employment and mail (postmark) such payments by the 15th day of the month following the month in which your work was performed. By way of example, January hours generate employer contributions in February which are posted on the Plan's books in March. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for FICA, FUTA, or state or federal taxes.

The Trust Fund Office checks the Employer's report for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, the Apprenticeship Program and others not working under a bargaining agreement) may be governed by individual Subscription Agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. **Loss of Eligibility if no Contributions:** You could lose eligibility with the Plan if the Employer contributions are not timely received by the Trust Fund Office, depending upon your hour bank and how soon the Employer makes the late contributions. If the Employer contributions are eventually received, retroactive eligibility may be granted for a Participant. It is the Participant's responsibility to determine whether he or she has sufficient hours and Employer contributions for eligibility.

6. **Availability of Fund Resources**: It is recognized that the benefits provided through this Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation of a Contributing Employer to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder.

There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

7. **Funding Methods and Benefits**: The Board of Trustees may provide benefits by self-funding, insurance, an HMO or by any other lawful means or methods. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

8. **Special Exclusion for Fraud:** No benefits will be paid for fraudulent claims of service or supplies by a Participant, eligible dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Employee and any person on whose behalf a fraudulent claim was submitted as a dependent of the Employee will be liable to the Plan for repayment of any benefits paid on behalf of the Employee or any eligible dependent of the Employee against the amount which was fraudulently paid on behalf of the Employee or the other person.

If an Employee or an eligible dependent of the Employee has any outstanding liability for fraudulently paid claims, neither the Employee nor the Employee's eligible dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by an Employee or eligible dependent may be disregarded by the Plan, and payments of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulent claims have not been repaid when an Employee or eligible dependent incurs covered charges, the Employee or eligible dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited.

9. **Plan Year**. The Plan Year commences January 1 of each year and ends on December 31 of the same year.

D. YOUR RESPONSIBILITIES

1. **Your Mailing Address**. Be sure to keep the Trust Fund Office advised of changes in

your address so that you can continue to receive Plan information because you may be entitled to benefits in the future.

2. **Enrollment Form**. You should keep your enrollment form current date (add new spouse and dependent children with required proof). You are required to notify the Trust Fund Office if a dependent no longer meets the Plan's requirements (i.e., divorce, death and over-age dependents).

WARNING – FRAUD AGAINST PLAN

It is fraud if you are caught enrolling dependents that do not meet the Plan rules or failing to notify the Trust Fund Office once a dependent no longer meets the Plan's rules. It is your responsibility to timely notify the Trust Fund Office of any such change. You will be required to repay the Plan for any overpayments or improper payments, including any attorney's fees and costs incurred by the Plan to recover such improper payment.

3. **Beneficiary Form**. You should keep your beneficiary form up to date so that family members or others you want to receive your benefits receive them without delay. If you are married, benefits are automatically paid to your legal spouse *unless* he or she consents in writing before a notary. You should submit a new form if there is a change in life circumstance (marriage or divorce).

4. **Privacy Protected Health Information**. There are Privacy Rules and forms to protect you based on federal law. If you wish to authorize someone other than yourself to access your Protected Health Information, you must complete the Authorization Form and return it to the Trust Fund Office. Please refer to this Plan booklet section regarding HIPAA and your privacy rights under the law for more information.

ARTICLE VI. DEFINITIONS

Unless the context of subject matter otherwise requires, the following definitions shall govern in this Plan:

1. **Accident** means an incident that happens unexpectedly and unintentionally, resulting in physical injury.

2. **Active Employee** means each person who meets the eligibility rules under Eligibility for Benefits, described in Article VI.

3. **Allied Health Practitioner** means a practitioner of the healing arts (behavioral health practitioner, chiropractor, licensed acupuncturist, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist) 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.

4. **Board** means the Board of Trustees established by the Trust Agreement.

5. **Collective Bargaining Agreement** means the labor agreement between NECA, Reno Division and the IBEW Local 401, and any individual agreement between the Individual Employer and IBEW Local

401.

6. **Complications of Pregnancy** means all physical ailments suffered as a direct result of the pregnancy, outside of the effects of a normal pregnancy from a medical viewpoint. Complications of Pregnancy shall include, but are not limited to, conditions such as acute nephritis, nephrosis, cardiac compensation, missed abortion, ectopic pregnancy which terminated, caesarian section, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similarly medically diagnosed conditions. Complications of pregnancy shall not include false labor, physician-prescribed rest during the period of pregnancy, morning sickness and similar conditions not constituting a classifiably distinct Complication of Pregnancy.

7. **Contract Dental Provider** means a Dentist or other provider of dental services who has a contract with the Fund to provide covered services to Participants.

8. **Contract Hospital** means a Hospital that has a contract with the Plan under the Preferred Provider Plan.

9. **Contract Provider** means a physician, durable medical equipment provider, laboratory, or radiology facility or other contracted provider that has a contract with the Plan under the Preferred Provider Plan.

10. **Contributing Employer** means any business entity which is required by a collective bargaining agreement between the Union and the Association to make payments into this Plan. "Contributing Employer" shall also include any other business entity whose participation is permissible under applicable laws (including the Union on behalf of its own employees), that contributes to the Fund with the approval of the Board and in accordance with such conditions as the Board may from time to time require under written agreement to assure the financial integrity of the Trust and equity among Employers and Participants.

11. **Convalescent Hospital** means an institution which:

(i) is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour supervision of a Physician or graduate Registered Nurse (R.N.);
(ii) has available at all times the services of a Physician who is a staff member of a general Hospital;
(iii) has on duty 24 hours a day a graduate Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.), or skilled practical nurse;
(iv) has a graduate Registered Nurse (R.N.) on duty at least 8 hours per day;
(v) maintains a daily medical record for each patient;
(vi) complies with all licensing and other legal requirements; and
(vii) is not, except incidentally, a place for rest, a place for custodial care, a place for the aged, for drug addicts, for alcoholics, a hotel or similar institution.

12. **Covered Expense** means only those 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:

(i) the negotiated rate for services of a Contract Hospital or Contract Provider; and
(ii) the Scheduled Allowance for services of a Non-Contract Hospital or Non-Contract Provider; and
(iii) the contract rate between the health care provider and a plan with which this Plan is coordinating benefits.

13. **Deductible** means the amount of eligible charges that each covered person or family must incur in each Calendar Year before benefits under the Plan will be paid. The deductible applies separately to each family member. However, when two or more family members have satisfied the family deductible amount in a calendar year, the family deductible will be deemed satisfied for the remainder of the calendar year.

14. **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 the deductible, those charges will be applied toward that person's medical deductible for the next calendar year.

15. **Dentist** means a dentist licensed to practice dentistry in the state in which he renders treatment. The term "Dentist" will also include a licensed dental hygienist working under the supervision and direction of a Dentist.

16. **Dependent** means:

(i) **the Active Employee's lawful spouse**. Lawful "spouse" will be interpreted to include same-sex spouses and means the person who is recognized as the Employee's spouse in accordance with the laws of the State, the District of Columbia, United States territory or foreign jurisdiction where the marriage took place.

(ii) **the Active Employee's children and grandchildren through age 25**, if they are:

(a) Natural children, Legally adopted children (from the date of placement or custody) or a Ward/Grandchildren (if a permanent legal guardianship has been ordered by a court of competent jurisdiction) or Other Eligible Dependent Children; or

(b) Stepchildren or Foster children (provided the foster children are placed in the employee's care by court order or a recognized social agency); or

(c) Disabled Dependent Children older than 25 years of age and prevented from earning a living because of mental or physical handicap (provided the disabled children were so handicapped and eligible as Dependents at the time they reached such limiting age) and are solely dependent upon the Active Employee for support. Evidence of the child's dependence and incapacity must be filed with the Board by the later of (a) the 31st day after attaining age 26, or (b) the 31st day after notice of incapability of such dependent child has been received by the Active Employee. Proof of the continued existence of such incapability shall be furnished to the Trustees from time to time at their request; or

(d) Children who are required to be covered by the eligible Active Employee by a Qualified Medical Child Support Order (QMCSO). The Fund may require documentation of the relationship of the Dependent and the employee. The Fund's procedures shall be provided without charge; or

(e) Temporary guardianship (not to exceed six (6) calendar months) if the ward has been claimed as a dependent (being supported by and lives with the guardian) for the prior year on the guardian's tax returns and a permanent guardianship petition has been filed with a Court of competent jurisdiction; or

(f) In accordance with Michelle's Law, dependent students beyond age 26 who were continuously

covered as an eligible Dependent prior to the first day of the leave of absence, and would otherwise lose coverage because of a medically necessary leave of absence from a post-secondary educational institution will get continued coverage, before the date that is the earlier of:

(i) date that is one (1) year after the first day of the medically necessary leave of absence; or

(ii) date on which such coverage would otherwise terminate under the terms of the Plan.

Medically necessary leave of absence means with respect to a dependent child, a leave of absence from or other change in enrollment status in a post-secondary educational institution that begins while the child is suffering from a serious injury or illness; is medically necessary; and causes the child to lose student status for purposes of coverage under the terms of the Plan.

17. **Emergency** means a medical condition manifesting itself by acute symptoms of sufficient severity including sever pain so 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 a condition described in clause (i), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual or with respect to a pregnant woman the health of the women or her unborn child in serious jeopardy; clause (ii) which refers to serious impairment to bodily functions and clause (iii) refers to serious dysfunction of any bodily organ or part.

18. **Essential Health Benefits** 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.

19. **Experimental and/or Investigational** means a service or supply that has been deemed as such by the Plan Administrator. The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as "Experimental" and/or "Investigational." A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, 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 under the Plan's Prior Authorization/Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

(i) The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

(ii) In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative

medical, or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

Authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:

(a) "United States Pharmacopeia Dispensing Information";
(b) "American Hospital Formulary Service";
(c) "American Medical Association (AMA), Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program", or similar publications of the AMA;
(d) specialty organizations recognized by the AMA;
(e) the National Institutes of Health (NIH);
(f) the Center for Disease Control (CDC);
(g) the Agency for Health Care Policy and Research (AHCPR);
(h) Opinions of other agency review organization, e.g. ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries;
(i) the American Dental Association (ADA), with respect to dental services or supplies; and
(j) the latest edition of "The Medicare Coverage Issues Manual."

(iii) With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an "investigational new drug for treatment use"; or 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 has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

(iv) The prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

20. Federal Medicare or **Medicare** means the benefits provided under Title XVIII of the Social Security Amendments of 1965.

21. Fund means the Electrical Workers Health and Welfare Trust Fund for Northern Nevada.

22. Grandfathered Health Plan means a plan that was in existence on March 23, 2010, when the Affordable Care Act was signed into law and is exempt from certain health care reform mandates. For example, a grandfathered health plan is not required to comply with the provision of providing preventive health services without any cost sharing and is not required to provide access to emergency, pediatric, obstetric and gynecological care without prior certification or limitation. Grandfathered health plans must comply,

however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime dollar limits on the Plan's Essential Health Benefits, dependent coverage up to Age 26, and cannot impose pre-existing condition exclusions. This Plan is a Grandfathered Health Plan.

23. Hospice Care means treatment incurred during a period for which the Plan validates a Physician's certification of a Participant is terminally ill, and during the bereavement Period. "Terminally ill" means that the patient has a life expectancy of six months or less.

24. Hospital means only an institution which meets all of the following tests:

(i) primarily provides medical treatment to registered inpatients;
(ii) maintains facilities for diagnosis;
(iii) provides treatment only by or under a staff of physicians;
(iv) provides 24 hour-a-day care by Registered Nurses;
(v) maintains permanent therapeutic facilities for surgical care;
(vi) maintains a daily medical record for each patient; and
(vii) complies with all licensing and other legal requirements:
(viii) a facility certified by the state for treatment of alcohol or drug abuse; or
(ix) a place which provides a program for the treatment of alcohol or drug abuse as part of its accredited activities.

For benefits provided for treatment of mental, nervous or emotional disorders or conditions, an institution that lacks permanent facilities for surgery will be considered a Hospital and an institution that is primarily a place for the care of persons with mental, nervous or emotional disorders or conditions will be considered a Hospital, provided that such institutions meet all the other requirements applied to Hospitals.

25. Illness(es) means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes.

26. Infertility means 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.

27. Injury(ies) means physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

28. Intensive Care Unit means only a separate hospital service area which:

(i) is solely for treatment of patients in a critical condition;
(ii) continuously provides special nursing care and observation;
(iii) provides special lifesaving equipment;
(iv) contains at least two beds for critically ill patients; and
(v) provides at least one Registered Nurse in such are on a 24 hour-a-day basis.

29. Licensed Pharmacist means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

30. Medically Necessary means a medical service or supply will be determined to be Medically Necessary by the Plan Administrator or its designee if it:

(i) 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

(ii) Is determined by the Plan Administrator or its designee to meet all of the following requirements:

(a) It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury, and otherwise in accordance with generally accepted medical practice and professionally recognized standards; and

(b) It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider, or Health Care Facility; and

(c) It is an "Appropriate" service or supply given the patient's circumstances and condition; and

(d) It is a "Cost-Efficient" supply or level of service that can be safely and appropriately provided to the patient; and

(e) It is safe and effective for the Illness or Injury for which it is used.

(iii) A medical service or supply will be considered to be "Appropriate" if:

(a) It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment; and (b) 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.

(b) It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) 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.

(iv) A medical service or supply will be considered to be "Cost-Efficient" if it is no more costly than any appropriate alternative service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

(v) The fact that the Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

(vi) A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will not be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

31. Non-Contract Hospital means a hospital that **does not** have a contract in effect with the Fund under the preferred provider plan.

32. Non-Contract Provider means any physician, laboratory, radiology facility or any other provider that **does not** have a contract in effect with the Fund under the Preferred Provider Plan.

33. 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 benefits provided under the Plan consistent with the Affordable Care Act and lawful regulations issued thereunder.

34. **Participant** means each Active Employee and each of his/her Dependents.

35. **Patient** means that Participant who is receiving medical treatment, services, or supplies covered by the Plan.

36. **Physician** means a duly licensed Doctor of Medicine authorized to perform a medical or surgical service within the lawful scope of his/her practice.

37. **Plan** means this Plan.

38. **Plan Year** means January 1 through December 31 of any year.

39. **Preferred Provider Plan** means a program whereby Hospitals and various outpatient providers, as approved by the Board and amended from time to time, contract with the Fund to provide any and all necessary services to Participants payable on the basis of a negotiated rate.

40. **Pregnancy** is the condition of carrying a developing embryo in the uterus of an eligible employee and/or dependent spouse. There is no coverage for: (1) an eligible employee and/or dependent spouse's voluntary/elective termination of pregnancy unless the life of the eligible employee and/or dependent spouse is endangered; or (2) dependent child pregnancies; or (3) surrogate/gestational carrier pregnancies, including complications thereof. Complications of pregnancy will be considered as any other illness.

41. **Prescription Drug** means 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.

42. **Prior Authorization/Utilization Review (UR)** means a program whereby a Participant who is scheduled for an elective, non-emergency Hospital confinement must obtain review by the Fund. The Fund will 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.

43. **Reserve Account** means the account established for an employee to which are credited hours for which contributions are made by Contributing Employers or are required to be made to the Fund with respect to his/her work.

44. **Schedule of Allowances** means the description of covered benefits payable under the Plan and the maximum amount payable for certain benefits and/or services received by you and/or your eligible dependents from providers who are not contracted with the Plan as approved by the Board and amended from time to time. Such Schedule Allowance shall provide specific reimbursement levels for services received from a Non-Contract Hospital, laboratory/radiology facility, Physician, Dentist or other covered providers. The Schedule of Allowances applicable to non-contract providers is subject to change by the Board of Trustees at any time. To illustrate, let's say you obtain services from a non-contract provider and that provider bills $120 for a covered service which has a Schedule of Allowance of $100, the Plan's out-of-network benefit percentage will be applied to the Schedule of Allowance of $100. In this example, you will be responsible for your portion of the plan's applicable coinsurance as well as the additional $20 which exceeds the Schedule of Allowance of $100. **For a copy of the Schedule of Allowances please contact the Trust Fund Office.** The Plan does not use Usual Customary and Reasonable or Billed Charges.

45. **Skilled Nursing Facility** means an institution that is primarily engaged in providing inpatients with either

(i) Skilled nursing care and related services or patients who require medical or nursing care or
(ii) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons and that meets all of the following requirements:
(a) It is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour-a-day supervision of a physician or a registered nurse.
(b) It has available at all times the services of a physician who is a staff member of a general hospital.
(c) It has on duty 24 hours a day a graduate registered nurse (R.N.) licensed vocation nurse (L.V.N.), or skilled practical nurse, and it has a graduate registered nurse on duty at least 8 hours per day.
(d) It maintains a clinical record for each patient.
(e) It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for treatment of substance abuse, a hotel, or similar institution.
(f) It complies with all licensing and other legal requirements and is recognized as a "Skilled Nursing Facility" by the Secretary of Health, Education, and Welfare of the United States pursuant to Title XVIII of the Social Security Act of 1965.

46. **Trust Agreement** means the Trust Agreement establishing the Electrical Workers Health and Welfare Plan for Northern Nevada dated November 1, 1956, and any modification, amendment, extension or renewal thereof.

47. **Trust Fund Office** means the organization that is contracted with the Fund to operate and administer all provisions of the Plan

48. **Union** means the International Brotherhood of Electrical Workers Local Union No. 401.

49. **Uniformed Services** means the Armed Forces (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war of emergency.

50. **Well Child Care** means services up to Age 19. Includes immunizations approved by FDA at intervals recommended by the American Pediatric Association. Excludes immunizations required exclusively for travel.

ARTICLE VII. ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

A. ELIGIBILITY (Active Employees)

An Employee is eligible to participate in this Plan if he/she is an Employee of a Contributing Employer and works under a Collective Bargaining Agreement with IBEW Local 401.

1. Initial Eligibility Provisions for Collectively Bargained Employees

An hourly rate collectively bargained Employee is initially eligible for Benefits on the first day of the second month following a period of 12 or less consecutive months during which he worked **at least 480 hours** in

Covered Employment for one or more Contributing Employers. (Covered Employment is work under a collective bargaining agreement with IBEW Local 401.).

Example: ***You are a new employee and work a total of 480 hours combined for the months of February through May. Your coverage would begin July 1st since June is a skip/lag month.***

2. Maintenance of Eligibility/Hour Bank Maximum: 1080 Hours

After the Participant has satisfied the initial eligibility rules above, his/her hours in excess of 120 in a month will be credited to his/her hour bank. 120 hours are deducted from the Active Employee's Hour Bank Account for each month of eligibility, until insufficient hours remain in the account. **The maximum hours in an Hour Bank Account may not exceed 1080 hours (9 months) after the deduction of 120 hours for the current month's eligibility. Exception: For Sound and Communication workers Plan, the maximum hours in an employee's Reserve Account may not exceed 360 hours after the deduction of 120 for the current month of eligibility.** The purpose of the Hour Bank Account is to provide continued coverage for Participants who, due to circumstances beyond their control, would not otherwise be able to maintain such coverage through hours currently reported to the Plan by Contributing Employers. If you fail to have 120 credited hours in an eligibility month, the number of credited hours necessary to make up the difference will be deducted from your hour bank. **Your hour bank is not a vested benefit. The hours in your hour bank may, at any time, be limited, changed or extinguished through Trustee action. Your hour bank also has no monetary value**.

Sufficient Balance in the Qualifying Month of...	Provides Coverage for the Corresponding Month of...
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February
January	March
February	April
March	May
April	June

3. Freeze of Balance in Hour Bank Account

If employment is interrupted due to an approved furlough or leave of absence due to uniformed services of the United States, the Employee is entitled to have any balance accumulated in his/her hour bank account frozen during a term of military service that terminated under honorable conditions, provided the Employee was an eligible Participant in the Plan immediately prior to the uniformed leave of absence, and the Employee's absence was due to a Uniformed Service leave approved by the Board of Trustees.

4. Termination of Active Employee Eligibility

Eligibility of an Active Employee will terminate on the earliest of any of the following dates:

a. For an hourly rate Employee, on the last day of the month in which the Employee does not qualify under the eligibility rules above; or

b. For an hourly rate Employee, the first day of the calendar month for which the Reserve Account totals less than 120 hours; or

c. For a monthly rate Employee, the first day of the calendar month for which the required monthly Contribution is not make on behalf of the Employee; or

d. The date ending the premium period for which the last premium payment is made on the Employee's behalf; or

e. The date the Employee enters full-time service in the uniformed military service of any country, except as provided under Uniformed Services Employment and Reemployment Rights Act of 1994(USERRA); or

f. The date the Plan terminates.

5. Reinstatement of Active Employee Eligibility

If an Active Employee's eligibility terminates:

a. An hourly rate Employee will have eligibility reinstated on the first day of the calendar month next following the date the number of hours in his/her Reserve Account reaches a total of at least 120, provided the 120 hours were accumulated within 12 months immediately following the date his/her eligibility terminated. If eligibility is not reinstated within the 12-month period, any reserve hours in the Reserve Account will be forfeited and the Employee must reestablish initial eligibility.

b. If an Employee was eligible for Benefits as of the date of entry into the Uniformed Services of the United States, and upon completion of the period of service he/she notifies his/her Employer of his/her intent to return to employment as specified in the Uniformed Services Employment and Reemployment Rights Act of 1994, he/she shall reinstate eligibility. Eligibility shall be reinstated without exclusion or waiting period, except for disabilities that the Veterans Administration has determined to be service connected.

6. Eligibility Provisions for Non-Collectively Bargained Employees

To cover non-bargained employees, the Contributing Employer must make a written election to enroll all full-time non-collectively bargained employees. The Contributing Employer must sign a subscription agreement, which must be accepted by the Board of Trustees. The Contributing Employer shall make monthly contributions at a rate to be determined from time to time by the Board of Trustees.

Coverage for non-bargained employees of a Contributing Employer who elects coverage is effective on the **first day of the second month** following acceptance by the Board of Trustees, provided the contributions have been timely received.
A new employee will become eligible for coverage on the first day of the month following the first full calendar month of full-time employment, provided that the monthly contributions have been received. Full-time employment is defined as employment of 120 hours or more in a calendar month.

B. RECIPROCITY – When You Work in More than One Area

1. PUPROSE

Eligibility for benefits is provided for Employees who would otherwise be ineligible for health and welfare benefits because their hours of employment have been divided between different health and welfare funds. The provisions are operative only if The Electrical Industry Health and Welfare Reciprocal Agreement has been adopted by the signatory funds (herein referred to as Participating Trust Funds) in whose jurisdiction the Employee works.

2. HOME FUND

A Temporary Employee's Home Fund shall be established under the rules set forth below. If the Temporary Employee cannot satisfy the conditions of these rules, he shall have no Home Fund and shall not be eligible to have contributions transferred pursuant to this agreement.

a) A Temporary Employee for purposes of this plan is defined as an Employee employed temporarily outside the jurisdiction of his/her Home Fund, which is a party hereto, and within the jurisdiction of another Trust Fund which is also a party to this agreement.

b) If the Temporary Employee belongs to an IBEW local union, his/her Home Fund shall be the Participating Trust Fund which is operative within the jurisdiction of the local union to which the Temporary Employee belongs if he has been eligible for benefits in the jurisdiction of that Fund during any time in the past six years.

c) If the Temporary Employee does not meet the conditions under the preceding subparagraph (2), his/her Home Fund shall be the Participating Trust Fund in which the Temporary Employee has currently obtained eligibility for benefits if the Temporary Employee intends to return to in the jurisdiction of such fund as soon as work is available. Rules establishing return to work requirements shall be the responsibility of each Participating Trust Fund.

A Permanent Employee for purposes of the plan is defined as an Employee employed within the jurisdiction of the IBEW local union of which he is a member or within the jurisdiction of his/her Home Fund.

3. CONTRIBUTIONS

The Participating Trust Fund shall remit monies to the Home Fund based on hours paid and reported to the Participating Trust Fund multiplied by the straight-time current contribution rate of the Home Fund, except that a Participating Trust Fund shall not be required to transfer funds at a contribution rate greater than the current rate of the Participating Trust Fund. The current contribution rate shall be defined as the prevalent rate currently being paid within the jurisdiction of the Fund.

4. EMPLOYEE AUTHORIZATION

If a Temporary Employee has contributions made to a Participating Trust Fund on his/her behalf, he may file a request to the Participating Trust Fund to have such Contributions made on his/her behalf, during any period of time, transferred to his/her designated Home Fund in his/her behalf if he/she is not then eligible for benefits in the Participating Trust Fund. Such a request submitted by the Temporary Employee must be an approved form and signed by the Temporary Employee. It shall release the Trustees of the Participating Trust Fund from any future claims, by the Temporary Employee or anyone making claim through him.

Should a Temporary Employee desire cessation of the transfer of contributions from a Participating Trust Fund to his/her Home Fund, he/she must indicate such in writing. This notice shall become effective to stop the transfer of funds on the last day of the month in which the notice is signed

and delivered to the Participating Trust Fund administrative office. A copy of such request for the cessation of transfer of Contributions must be sent to the Temporary Employee's Home Fund by the Participating Trust Fund.

5. TRANSFER OF CONTRIBUTIONS

When a Participating Trust Fund receives a timely and properly completed request for a transfer of contributions to a Temporary Employee's Home Fund, it shall remit to the Home Fund Contributions received on behalf of the Temporary Employee from the first day of the month that the Temporary Employee signs the form requesting participation in reciprocity, provided however, that such form is received in the office of the Administrator of the Participating Trust Fund no later than the tenth day of the month following the date on such application, otherwise the effective date for forwarding contributions to the Temporary Employee's Home Fund shall be the date his/her application was received in the office of the Administrator of the Participating Fund.

Each Participating Trust Fund shall transfer required contributions to the Temporary Employee's Home Fund as soon as feasible within a period of sixty (60) days following receipt of the request for transfer. Subsequent transfers of money to the Home Fund shall be made on a least a monthly basis or more often is mutually agreed to by the parties to this agreement.

5. ELIGIBILITY CREDITING

The manner of crediting its respective contributions received on behalf of members employed temporarily elsewhere shall be left to the discretion of the Home Fund. All payments forwarded, pursuant to this plan, to the Home Fund shall be deemed contributions to that Home Fund as if made directly by the employer of said Home Fund and shall be applied in accordance with said Home Fund's provisions. Neither the Trustees not the Participating Trust Fund forwarding payment to the Home Fund shall have any responsibility for the application of any payment forwarded to the Home Fund.

It is expressly understood and agreed that none of the Participating Trust Funds assumes any of the liabilities or obligations of the other Participating Trust Funds. Each Participating Trust Fund shall be liable solely and exclusively for health and welfare benefits due under its own plan, and no Fund shall be liable for acts or omissions of another Fund.

C. SELF PAY PROVISION

A former Active Employee may elect to continue coverage for himself and his/her Dependents by making direct payments after exhausting his/her COBRA continuation coverage, once in a lifetime. Dependents must have been covered under the COBRA continuation coverage to be eligible for coverage under the direct-pay provision. The following provisions will apply:

1. Types of Benefits Provided

The former Active Employee will have a choice of coverage as follows:

(i) Full coverage – consisting of Comprehensive Medical Benefits; or
(ii) Full and Non-Core Coverage – consisting of Comprehensive Medical plus Dental and Vision Care benefits;

The coverage provided is to be identical to the coverage that is provided to other Active Employees. However, an individual who selected COBRA core coverage only must continue the same coverage. Coverage may not be increased to include Full Coverage benefits.

2. Duration of Coverage

After exhausting COBRA coverage, direct-pay coverage will continue for no more than a total of thirty-six (36) months during the former Active Employee's lifetime. Coverage for Dependents must be elected at the time that direct-pay coverage is elected. Coverage for former Active Employee and/or Dependents, if covered under the direct-pay provisions, will terminate on the earlier of:

(i) A total of 36 months during the former Active Employee or Dependent's lifetime;

(ii) The date on which the Spouse of the former Active Employee becomes eligible for Medicare; or

(iii) The date on which the Dependent ceases to meet the definition of Dependent as described in Article V.

Dependents (if covered under the direct-pay provisions) will be eligible to continue direct-pay coverage upon the death of the former Active Employee, subject to the duration of coverage limitations above.

3. Payment

Payment requirements for direct-pay coverage are as follows:

(i) The direct payments shall be in an amount determined by the Board of Trustees as amended from time to time.

(ii) The direct payments must be continuous from month to month.

(iii) The direct payments must be received by the Trust Fund Office prior to the last day of the month for which coverage is effective.

(iv) Provided the provisions noted on page 22 are met, direct payments may continue up to a maximum of 36 months.

d) Addition of New Dependents

If, while enrolled for direct-pay coverage, the former Active Employee marries, has a newborn child or has a child placed for adoption, he may enroll the new Spouse or Child for coverage for the balance of the period of direct-pay coverage by doing so within 30 days after the marriage, birth or placement for adoption.

5. Extension of Benefits Upon Death of An Active Employee

The Surviving Dependents of an Active Employee continue to be eligible for the same coverage until the deceased Active Employee's Reserve Account hours are exhausted. Such Dependents may then become eligible for 36 months of COBRA continuation coverage.

6. Extension of Benefits for Total Disability

If the Participant is Totally Disabled when coverage ends due to loss of eligibility and that individual is under the treatment of a Physician, Comprehensive Medical Benefits shall continue to be provided only for services treating the totally disabling Illness or Injury. These benefits are provided until one of the following occurs:

(i) The Participant is no longer Totally Disabled;
(ii) The maximum Comprehensive Medical Benefits are paid;
(iii) Up to a maximum of 12 months from the month in which eligibility is terminated; or
(iv) The Participant becomes covered under any other plan providing similar benefits.

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 coverage ends. At least once every 90 days while benefits are extended, Fund must receive proof that he continues to be Totally Disabled.

For purposes of this Section, the term "Totally Disabled" shall mean:

(i) With respect to the Active Employee, as a result of Injury or Illness, he is unable to engage in his/her regular and customary occupation.
(ii) With respect to a Dependent, as a result of Injury or Illness, he or she is prevented from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

D. CONTINUATION OF COVERAGE - COBRA COVERAGE

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires group health plans offer covered Employees and their Dependents the opportunity to elect to pay for a temporary extension of health coverage (called "COBRA Continuation Coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage, the Employee, spouse and/or Dependent(s) must make timely monthly payments directly to the Plan.

When a Participant no longer has sufficient hours in his/her Reserve Hour Bank, his/her COBRA coverage will run concurrently with any continuation of coverage described in this booklet. In other words, the COBRA eligibility time period is reduced by the number of months of free or subsidized coverage.

Coverage under the Plan may be extended by making self-payments for specified periods. To maintain continued coverage, an Employee whose coverage has terminated because of a qualifying event (see Section B below) may elect to continue coverage as set forth below.

Even if the participant does not elect COBRA continuation coverage, your Spouse and each eligible Dependent have a separate right to elect it.

1. **CONTINUED COVERAGE** - "Continued coverage" shall mean only a Covered Person's coverage that the Covered Person keeps in force by the terms of this provision. The Covered Person's continued coverage options shall include:

a. FULL COVERAGE: provides coverage for medical and prescription drug coverage only, or
b. FULL AND NON-CORE COVERAGE: provides coverage for medical plus any dental, vision or prescription drug coverage.

If you elect COBRA, you will be entitled to the same health coverage that is provided to Active Employees and Dependents in the Plan. Therefore, if there are any changes to the Plan for Active Employees, your benefits will also change.

2. **QUALIFYING EVENTS** - Continued coverage is required if one of the following qualifying events results in the Covered Person's coverage ending:

a. the Employee's death;
b. the termination of employment (including retirement) for a reason other than gross misconduct;
c. reduction of the Employee's work hours;
d. divorce or legal separation from spouse;
e. becoming entitled to benefits under Medicare; or
f. a Dependent child ceasing to be eligible as a Dependent under this Plan.

3. NOTIFICATION REQUIREMENTS - A Covered Person who wants continued coverage because of a qualifying event shall notify the Trust Fund Office of a change in family status within 60 days after it occurs. A change in family status means: (a) divorce or legal separation from his/her spouse; or (b) a child's ceasing to be eligible as a Dependent under this Plan.

Failure to give timely notification will end your eligibility for continued coverage due to the change in family status.

Within 44 days after the Covered Person notifies the Trust Fund Office of a qualifying event, the Trust Fund Office shall notify a Covered Person who is eligible for continued coverage of the following:

a. the Covered Person's right of continued coverage;
b. the amount that shall be paid each month to continue the coverage; and
c. how, when and to whom the monthly payments shall be made.

Notice that is given to a Covered Person's spouse (or former spouse) is deemed to be given to each child who lives with the spouse and whose coverage would end due to the same qualifying event.

Qualifying Event Notice Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for you (or your Dependents) right to notify the Trust Fund Office of a Qualifying Event. This means Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the period to give a Qualifying Event Notice will be temporarily tolled until 60 days after the end of the Outbreak Period.

Trust Fund Office COBRA Notice Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") the Trust Fund Offices obligation to notify you (or your Dependents) of your COBRA election right (after you or dependent notifies the Trust Fund Office of a Qualifying Event) will be extended to as soon as administratively practicable under the circumstances if the Trust Fund Office acts in good faith to furnish the written notice. Good faith acts include the use of electronic alternative means of communicating with Qualified Beneficiaries who the Fund Office reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.

4. REQUEST FOR CONTINUED COVERAGE - When a Covered Person has been given notice of the right to continued coverage, the Covered Person must request continued coverage in writing within 60 days after:

a. the date of the notice of the right to continued coverage; or
b. the date coverage under this Plan otherwise would end, whichever is later.

A request for continued coverage will be deemed to include Covered Dependents unless requested that it not include them. A request by a spouse may include Covered Dependents who live with the spouse. If you do not elect COBRA Continuation Coverage, each of your dependents may independently elect such coverage on his/her behalf and pay the required premiums.

COBRA Election Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective

immediately and only during the public health emergency, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for you (or your Dependents) your 60 day right to elect COBRA upon receipt of the election notice. This period is temporarily tolled until after the end of the Outbreak Period, calculated from the later of the date of the Qualifying Event, if the Qualifying Event is a divorce or a child losing Dependent status, or the date the Qualified Beneficiary loses coverage. For Qualifying Events occurring on or after March 1, 2020, this period is extended until the end of the sixty (60) period after the end of the Outbreak Period

5. **PAYMENTS FOR CONTINUED COVERAGE** - The Covered Person's first payment shall be for the period of continued coverage beginning on the first day following the date of the qualifying event and ending on the last day of the month following the date on which the written request for the continued coverage is made. This payment shall be due no later than the 45th day after the date on which the Covered Person's written request for continued coverage is given to the Trust Fund Office, or, if mailed, on the 45th day after the date the written request is postmarked.

Thereafter, the Covered Person shall pay monthly for the continued coverage. The monthly payment shall be no more than 102% of the current full monthly cost for the coverage under this Plan except that during the additional 11 months of continued coverage provided for a disabled Employee, the monthly payments shall be no more than 150% of the current full monthly cost for the coverage.

COBRA Premium Payments Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for you (or your Dependents) the initial COBRA payment and ongoing monthly premium payments. This means if COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily due no later than the end of the 45 day period after the end of the Outbreak Period. For all ongoing monthly premium payments, coming due during the Outbreak Period are temporarily due no later than 30 days after the end of the Outbreak Period because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 days of the due date.

6. **TERMINATION OF CONTINUED COVERAGE** - Except as provided below, eligibility for continued coverage shall end on the earlier of the following:

a. **COBRA time period ends.** The end of the 18-month period following the date of the qualifying event, if the event is the termination of employment or reduction of work hours unless the reason is for gross misconduct;

COBRA time period ends – 36 months situation – Spouse or Dependents. The end of the 36-month period following the date of any of the following qualifying events: (a) death, (b) divorce or legal separation from spouse, (c) becoming entitled to benefits under Medicare, or (d) a child ceasing to be eligible as a Dependent under this Plan;

b. **Failure to timely pay COBRA Premium.** The end of the month for which a Covered Person has made the required payment for continued coverage; the date on which any payment for continued coverage is not made in a timely manner. A payment shall be considered received in a timely manner if it is received within 31 days after becoming due;

c. **Coverage under another Plan.** The date a Covered Person becomes covered under another group health plan;

d. **Entitled to Medicare.** After an election of COBRA coverage, the date a Covered Person becomes entitled to benefits under Medicare;

e. **No Active Plan Coverage.** The date on which the Plan ends coverage for the Covered Persons to which a person receiving continued coverage belonged to before his/her continued coverage began.

e. **Employer no longer contributes.** The date your employer, who contributed on your behalf, ceases to be a contributing Employer.

g. **Disability Ends.** The person was receiving extended coverage for up to 29 months due to his/her or another family member's disability, and Social Security determines that he or the other family member is no longer disabled.

7. *COBRA QUICK REFERENCE CHART*

An illustration of circumstances under which health benefits can be continued, and the maximum duration of COBRA Continuation Coverage are summarized in the following chart:

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
(1) Reduction in eligible Employee's hours	Employee spouse and dependent children covered under Plan	18 mo. after Qualifying Event
(2) Termination of eligible Employee's employment except for gross misconduct	Employee, spouse and dependent children covered under Plan	18 mo. after Qualifying Event
(3) Death of eligible Employee covered under Plan	Spouse and dependent children	36 mo. after Qualifying Event
(4) Divorce or legal separation of eligible Employee	Spouse and dependent children covered under Plan	36 mo. after Qualifying Event
(5) Dependent child's loss of that status under Plan	Affected dependent child if covered under Plan	36 mo. after Qualifying Event
(6) Eligible Active Employee's entitlement to Medicare after a qualifying event described in (1) or (2)	Spouse and dependent children covered under Plan	36 mo. after initial Qualifying Event
(7) Eligible Active Employee's entitlement to Medicare before a qualifying event described in (1) or (2)	Spouse and dependent children covered under Plan	Later of: (1) 18 mo. from Qualifying Event or (2) 36 mo. from date of Employee's Medicare entitlement
(8) Employee's retirement, if all qualifications are met	Employee, spouse and dependent children covered under Plan	Retired Employee's Medicare entitlement

8. EXCEPTIONS TO TERMINATION OF CONTINUED COVERAGE - Section F above shall not be applicable in the following situations:

a. If the Covered Person is Disabled. For an additional premium equal to 150% of the cost of coverage, the maximum period of continued coverage shall be extended beyond 18 months for an additional 11 months if (a) the Covered Person is determined by the Social Security Administration to have been disabled within 60 days of the date of the qualifying event or the loss of coverage, (b) the Covered Person furnishes notice of Social Security's determination of disability to the Trust Fund Office before the end of the initial 18 month period of continued coverage, and (c) the Covered Person remains disabled until the end of the combined 29 month period of continued coverage. The continued coverage shall stop, however, at the end of the month following any one of the additional 11 months during which the Social Security Administration makes a final determination that the Covered Person is no longer disabled.

b. If another qualifying event occurs. If a subsequent qualifying event occurs with a maximum period of 36 months of continued coverage while a Covered Person and his/her Covered Dependents are receiving 18 months of continued coverage due to an initial qualifying event, the maximum period of continued coverage for Dependents only shall become 36 months from the date of the initial qualifying event.

c. **If Medicare is not a qualifying event.** If a Covered Person becomes entitled to benefits under Medicare, but that is not a qualifying event because coverage does not end for that reason, and subsequently, a qualifying event occurs entitling the Covered Person and his/her Covered Dependents to 18 months of continued coverage, the maximum period of continued coverage for Dependents only shall be 36 months from the date the Employee became entitled to Medicare.

ALERT
Medicaid and the Children's Health Insurance Program (CHIP)
Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in certain States, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your Plan is required to permit you and your dependents to enroll in the Plan as long as you and your dependents are eligible, but not already enrolled in the Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in Nevada, you may be eligible for assistance paying your employer health plan premiums. You may contact your State for further information on eligibility as follows:

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

ALERT – COVERAGE AND BENEFITS CAN BE CHANGED

IN ALL CASES, INITIAL ELIGIBILITY AND CONTINUING ELIGIBILITY FOR RETIREE COVERAGE DEPENDS ON THE BOARD OF TRUSTEES CONTINUING RETIREE BENEFITS. THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHARGE FOR, MODIFY OR TERMINATE THE RETIREE BENEFITS AT ANY TIME. RETIREE BENEFITS ARE NOT A VESTED RIGHT.

E. COVERED DEPENDENTS

A Covered Dependent means a lawful spouse, child, or children through the end of the month in which the child attains age 26 regardless of whether the child is eligible for coverage through his/her own employment and/or through the dependent child's spouse's employment. If the Participant and spouse are legally

separated or divorced, the spouse is no longer eligible for coverage.

For purposes of coordination of benefits, the insurance that covers the dependent child because of his/her own employment or his/her spouse's employment will be primary (and pay prior to this Plan providing benefits). This Plan will be secondary.

NOTICE OF NEW DEPENDENT

Employees must provide written proof to the Fund Office of their legal Dependent in order for Dependents to be eligible for the benefits of this Plan. For example, a copy of your marriage certificate for a spouse, a copy of a birth certificate for a child, a copy of a decree of adoption for an adopted child and copy of court order showing legal guardianship should be submitted. Nothing in this Section is intended to modify the Plan's coordination of benefit provisions.

1. Dependent Spouse

A spouse becomes eligible as of the date of marriage, provided the Participant has submitted an updated Enrollment Form adding the spouse along with a certified marriage certificate within 60 days of the date of marriage. You are encouraged to provide proof of your marriage as soon as possible after you marry if you wish to add coverage for your new spouse.

A former spouse is not eligible for coverage under the Plan, except as required by COBRA. Eligibility and/or coverage terminates effective the last day of the month in which a divorce, legal separation, or annulment is final, subject to COBRA. The Participant is required to notify the Plan of any such change within 30 days of such change.

2. Dependent Children

Children include the employee's biological child, stepchildren, foster children, or legally adopted children and any child for whom the Participant is the legal guardian.

Newborn eligible Dependents will be considered eligible from the date of birth for Benefits under the Plan, provided they are enrolled in the Plan within 30 days from the date of birth.

Newly acquired Dependents become eligible on the date acquired, provided they are enrolled in the Plan within 30 days after the date the new Dependent is acquired.

A Covered Dependent adult child who is incapable of self-sustaining employment due to mental or physical handicap is chiefly dependent upon the Employee for support, and was so handicapped and eligible as a Dependent, shall not have his/her medical coverage terminated because he or she has reached age 26. However, the Board of Trustees may establish an age limit at any time in the future for such disabled adult children, require additional premiums for such coverage, or provide for any other special rules. Evidence of the child's dependence and incapacity must be filed with the Board within 30 days after attaining age 26, and periodically thereafter.

Children under the age of 26 who are required to be covered by the Eligible Employee by a Qualified Medical Child Support Order (QMCSO) are also covered under the Plan. See Section 12.15 for the definition of a QMCSO.

Active Employees shall register their eligible Dependents upon forms provided by the Fund and shall furnish

such other information regarding family status as the Trustees may require from time to time. Marriage certificates are required to provide coverage for a spouse under the Plan. Birth certificates are required to provide coverage for a Dependent child under the Plan. Copies of Social Security Number Cards for All Dependents are also required.

F. EMPLOYEE AND/OR DEPENDENT/COST OF COVERAGE

An Employee and his/her dependents may be required to contribute toward the cost of the coverage provided in the Plan.

G. TERMINATION OF DEPENDENT ELIGIBILITY

A Dependent's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan qualifications of an eligible Dependent. Terminations occur as follows:

1. The date the person ceases to be a Dependent as defined in the Plan.

2. The date that the Participant who has Covered Dependents ceases to be eligible under the Plan.

H. DEATH OF AN EMPLOYEE

Upon the death of an Employee with eligible Dependent(s) under the Plan, such Dependents shall continue to be eligible for benefits until the deceased Employee's reserve hours are exhausted. Such Dependents may then become eligible for Retiree coverage, provided the Retiree coverage eligibility requirements by the Employee are met as described in the Retiree Eligibility section (refer to section 2.03).

Benefits terminate on the date the surviving spouse remarries, the Dependent child is no longer an eligible Dependent, or becomes eligible for coverage under any other group plan.

I. SPECIAL ENROLLMENT RIGHTS

Other than during Open Enrollment, the Plan is required to provide Special Enrollment Rights to you and your eligible Dependents upon the following events pursuant to Federal law:

a. Loss of Other Coverage: If you did not enroll yourself and/or your eligible Dependents because you and/or your Dependents had other group health coverage or other health insurance, including COBRA continuation coverage, and showed the Trust Fund Office evidence of such other coverage, you and/or your eligible Dependents may enroll in this Plan during a Special Enrollment period. This Special Enrollment period is a 30-day period which begins when you lose the other coverage. To take advantage of this Special Enrollment Right, you and/or your Dependents must enroll in the Plan within 30 days of exhausting COBRA continuation coverage or the termination of such other coverage as a result of a loss of eligibility for coverage (such as a divorce, legal separation, death, termination of employment, reduction in the number of hours, ceasing to reside, , or dependent ceasing to qualify as a dependent under the other plan).

b. Acquire New Dependents: Newly acquired eligible Dependents, including your legal spouse, newborn, adopted child(ren) or step child(ren), will be covered from the time of birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form and appropriate documentation to the Trust Fund Office as soon as reasonably possible from the date of the

birth, adoption, placement for adoption, or marriage.

c. Special Enrollment Allowed Under The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP): The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) created a special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit yourself and/or your eligible dependents with group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or CHIP coverage; or
- Become eligible to participate in a premium assistance program under Medicaid or CHIP

In both cases you and/or your eligible dependent must request special enrollment within 60 days (of the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

d. Special Enrollment Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency unless extended by federal mandate, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for you (or your eligible Dependents) the 30-day or 60-day period for special enrollment rights. This means if you had a birth, marriage or adoption as of March 31, 2020, your 30-day period right to special enroll an eligible dependent in the Plan upon birth, marriage, or adoption has been extended until 30 days from the end of the Outbreak Period. If you or your dependent lost coverage under CHIPRA or Medicaid, you or your dependent's 60-day period to special enroll in the Plan upon a loss of CHIPRA or Medicaid coverage has been extended until 60 days from the end of the Outbreak Period.

ARTICLE VIII. MEDICAL BENEFITS (Covered Expenses)

REMINDER- IT IS THE PARTICIPANTS' RESPONSIBILITY TO:

- **Follow the cost containment requirements for emergency room services and for non-emergency hospital stays (Article III).**
- **Contact the Trust Fund Office to determine if a provider is a "contract provider".**
- **Notify the Trust Fund Office of changes in dependent eligibility. You may be required to reimburse the plan for non-eligible participant benefit payments.**
- **Notify the Eligibility Department at the Trust Fund Office of any changes in your home address.**

The benefits described below are provided for Covered Expenses incurred for Medically Necessary treatment of a covered Illness, Injury, or Pregnancy. Expense is incurred on the date the Participant receives the service or supply for which the charge is made. These benefits are subject to all provisions of these Plan, which may limit benefits or result in benefits not being payable.

A. DEDUCTIBLE AMOUNT

1. All Employees (Except Sound and Communication Workers)
The Deductible for each Participant is the first $200 of Covered Expense incurred in a calendar year, with a maximum of $400 per family, to be incurred by two or more family members.

2. Sound and Communication Workers Plan
The Deductible for each Participant is the first $300 of Covered Expense incurred in a calendar year, with a maximum of $600 per family, to be incurred by two or more family members.

Covered Expenses incurred during the last calendar quarter of a year that are applied against the Deductible for that year shall also be applied toward satisfaction of the Deductible for the ensuing year.

B. COINSURANCE PERCENTAGE

1. All Employees (Except Sound and Communication Workers)
Except as otherwise specifically stated, the coinsurance percentage is 80% for the first $5,000 of Covered Expenses per calendar year and 100% thereafter for all Covered Expenses for the remainder of the calendar year. The applicable percentages will apply to the negotiated fee for Contract Providers and to the Scheduled Plan Allowance for Non-Contract Providers as shown in Appendix A. Charges in excess of Covered Expenses are not applied toward the coinsurance limit.

2. Sound and Communication Workers Plan
Except as otherwise specifically stated, the coinsurance percentage is non-PPO 70% or 80% for the first $10,000 of Covered Expenses per calendar year and 100% thereafter for all Covered Expenses for the remainder of the calendar year. The applicable percentages will apply to the negotiated fee for Contract Providers and to the Scheduled Plan Allowance for Non-Contract Providers as shown in Appendix A. Charges in excess of Covered Expenses are not applied toward the coinsurance limit.

C. NO MAXIMUM LIFETIME BENEFIT

The lifetime dollar maximum benefit has been eliminated from the Plan.

D. COVERED EXPENSES

This section describes the Covered Expenses by type of service and the applicable benefits and provisions.

1. **Accident Supplemental Expense Benefit.** The first $300 of Covered Expenses (initial treatment sought within 72 hours) incurred for services rendered by a Hospital, Physician or Registered Nurse of an accident will be paid at 100%. Covered Expenses in excess of $300, or beyond the 72 hours following the accident, shall be subject to the deductible amount, percentages payable, and maximum benefits amount.

2. **Acupuncture.** Benefits for treatment of a certified acupuncturist (C.A.) are subject to the following conditions:

(i) the Treatment must be for a specific medically recognized Illness or Injury;
(ii) the Acupuncturist must be operating within the scope of his/her license;
(iii) the benefit is limited to 15 visits in a calendar year;
(iv) Acupuncture is limited to certain conditions; and
(v) The Plan does not cover most conditions because there has not been adequate scientific research to establish medical efficacy.

3. **ADD/ADHD.** Services of a Physician for medical treatment of ADD and ADHD, limited to two visits per calendar year.

4. **Alcohol or Substance Abuse.** Inpatient Alcohol or Substance Abuse treatment is covered at 75% of the PPO Contract Rate or Non-PPO Schedule Allowance. Inpatient treatment must be pre-authorized prior to the confinement or as soon as possible. No benefits are payable for inpatient or outpatient care in an acute care hospital, including charges made solely for detoxification. Outpatient Alcohol or Substance Abuse treatment is covered at 75% of the PPO Contract Rate or Non-PPO Schedule Allowance.

5. **Ambulance.** Charges from a licensed professional ambulance service for the ground transportation of a Participant to or from a Hospital or Convalescent Hospital where treatment is given. Licensed air ambulance is also covered if the Fund 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.

6. **Bariatric Surgery.** The plan will pay up to (1) one surgery per year for any medically necessary services related to Bariatric Surgery provided it is approved by the Centers for Medicare and Medicaid Services (CMS). Bariatric Surgery benefits will be paid in accordance with CMS coverage Guidelines for Treatment of Obesity and subject to the Plan's Schedule of allowances like any other medically necessary treatment under the Plan rules. Services will include but are not limited to pre-surgery labs, office visits, surgeon, anesthesia, pathology, facility and any follow up services that may be required up to the Treatment Limit. This surgery requires pre-certification by the Trust Fund Office prior to the surgery.

7. **Blood. Blood transfusions, including blood processing** and the cost of un-replaced blood and blood products. (Blood storage is not a covered benefit.)

8. **Botulin. Botulin toxin injections for chronic migraines** are subject to the following requirements:

(i) Pre-authorization must be obtained;
(ii) Botulin toxin injections for migraines must meet the U.S. Food and Drug Administration (FDA) guidelines;
(iii) Migraines must be chronic, meaning equal to or greater than 15 days per month with a headache lasting 4 hours a day or longer; and
(iv) Are limited to four (4) injections per calendar year.

9. **Breast Prosthesis. The initial External Breast Prosthesis purchased within one year after the mastectomy** is performed is covered under regular plan benefits. Two Post-Mastectomy Bras are covered per calendar year with doctor's orders.

10. **Cataract Surgery. Following cataract surgery the first lens replacement** is covered under the

medical plan.

11. **Chiropractic/Vertebrae, Spine, Back or Neck.** Covered Expenses are limited to 15 outpatient visits in any calendar year for treatment of:

(i) Dislocation of vertebrae, spine, back or neck;
(ii) Musculoskeletal sprain or strain surrounding vertebrae, spine, back or neck;
(iii) Subluxation of vertebra; and
(iv) Misplaced vertebra

The coinsurance percentages are:

Contract Provider	80% of contracted fees
Non-Contract Provider	**All Employees (Except Sound & Communication Workers):** 80% of non-PPO Scheduled Allowance (See Appendix A). **Sound and Communication Workers Plan**: 70% of non-PPO Scheduled Allowance (See Appendix A).

12. **Circumcision** is a covered benefit under the Plan.

13. **Convalescent Hospital or Skilled Nursing Facility.** If a Participant is confined in a hospital for at least three consecutive days and is then admitted to a Convalescent Hospital or Skilled Nursing Facility within seven days of the hospital discharge, the Plan will reimburse up to 50% of the semi-private room accommodation of the hospital from which the Participant was discharged, provided the Participant is under the care of the physician and has been referred to the facility by a physician. The maximum number of convalescent hospital or nursing facility days for which benefits will be paid during any one period of confinement is 100. Successive hospital confinements will be considered as one confinement unless separated by a period of 30 days or if the second confinement is due to a new injury or illness. Conditions of Service, include the following:

(i) Services must be those which are regularly provided and billed by a Convalescent Hospital.
(ii) The services must be consistent with the Illness, Injury, degree of disability and medical needs of the Eligible Individual, as determined by the PRO. Benefits are provided only for the number of days required to treat the eligible individual's illness or injury.
(iii) The eligible individual must remain under the active medical supervision of a physician. The physician must be treating the illness or injury for which the eligible individual is confined in the Convalescent Hospital.
(iv) Custodial care is not covered.

14. **Dependent Pregnancy.** Expenses in connection with the routine normal pregnancy of a Dependent daughter or other non-spousal dependent including medically necessary treatment of Complications of Pregnancy for a Dependent daughter will be considered as any other Illness.

15. **Diabetes Instruction Program.** Diabetes instruction program is limited to one class per calendar year. The diabetes instruction program must be under the supervision of a Physician and must be designed to teach the Participant and his/her family about the disease process and the daily management of diabetes therapy. Diabetes instruction program services may be rendered at a Hospital or outpatient facility, a Physician's office, or a Home Health Care program.

16. **<u>Diagnostic Radiology/Laboratory Services.</u>** Diagnostic radiology and laboratory services and the professional services of a radiologist or pathologist provided:

(i) Outpatient magnetic resonance imaging (MRI) and Computed Tomography Imaging (CT scan or CAT scan) must be pre-authorized prior to the service. **For a complete list of services that need preauthorization/precertification, please refer to APPENDIX B in the back of this booklet**.
(ii) Some laboratory providers are paid at 100% of contract rate with no deductible taken on the services. Modifiers for Non-Contract Providers: Modifier 26 – Allowable benefit is 40% of the Scheduled Allowance in **APPENDIX A**.

17. **<u>Durable Medical Equipment.</u>**

(i) **Artificial limbs or eyes for the initial replacement of natural limbs or eyes, excluding hearing aids and replacement of prostheses**. Generally, 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 ®)
(ii) **Oxygen and rental of equipment** for its administration, the benefit not to exceed the purchase cost for such equipment.
(iii) **Initial rental or purchase of a truss, brace or support, cast, splints or crutches**. Replacement (maximum of two per calendar year) of a truss, brace or support which cannot be made functional, when required due to definitive changes in the patient's medical/physical condition and ordered by a Physician. Replacement of a lost or broken truss, brace or support is not covered.
(iv) **Rental or purchase of durable medical equipment and supplies** which are:
(a) Ordered by a Physician;
(b) Of no further use when medical need ends;
(c) Usable only by the Patient;
(d) Not primarily for the comfort or hygiene of the Participant;
(e) Not for environmental control;
(f) Not for exercise;
(g) Manufactured specifically for medical use;
(h) Approved as effective and usual and customary treatment of a condition as determined by the Trust Fund; and
(i) Not for prevention purposes.

Rental charges are not covered if the rental charges are expected to exceed the price of the equipment. For any equipment with a purchase price greater than $1,000 the Fund may at the Trustees option purchase the equipment for the use of the Participant. Purchased equipment will remain the property of the Fund.

Fees incurred for maintenance agreements related to the purchase of oxygen concentrators are considered to be Covered Expense.

18. **<u>Emergency and Trauma Treatment</u>**. There is no limit to the number of Hospital Emergency room visits per participant (for each eligible member, spouse, or dependent child). Benefits are payable as follows:

Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% of the first $5,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year. **Sound and Communication Workers Plan:** 80% of the first $10,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year.
Non-Contract Provider	Benefits are payable as described in Appendix A.
Renown Trauma Center	Renown Regional Medical Center is a contracted provider for Trauma cases. Trauma claims will be processed according to the Renown PPO contract. **Sound and Communication Workers Plan:** Renown Regional Medical Center is a contracted provider for Trauma cases. Trauma claims will be processed according to the Renown PPO contract.

19. **Hearing Aids.** Upon certification by a Physician that a Participant has a hearing loss, and that such loss may be lessened by the use of a hearing aid, benefits are payable for expenses incurred for one examination and hearing aid device, up to a maximum benefit payment of $5,000 per hearing device or per pair ($2,500 each ear). Repairs and replacements are limited to once every three (3) years.

No benefits are provided for:

(a) A hearing examination without a hearing aid device being obtained;
(b) More than one hearing aid device for each ear;
(c) The replacement of a hearing aid device for any reason more often than once during any two-year period;
(d) Batteries or any other ancillary equipment, other than that obtained upon the purchase of the hearing aid device;
(e) Expenses incurred for which the Participant is not required to pay; or
(f) Repairs, servicing or alterations of the hearing aid device more often than once during any three-year period.

20. **Home Health Care and Health Supportive Services.** For home health care or health supportive services that would have been covered if the services had been performed in a Hospital or Convalescent Hospital, benefits are provided subject to the following:

(i) The services must have been prescribed by a Physician to be performed in a Participant's home and certification must be provided to the Fund that in the absence of such care, facility care would be required.
(ii) The services must have been prescribed as Medically Necessary for the care and treatment of an Illness or Injury immediately following a period of confinement in a Hospital or Convalescent Hospital.
(iii) The services must be performed by or under the supervision of a person who or agency that is licensed, certified or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a Hospital or Convalescent Hospital.
(iv) Periodic recertification of the necessity for such care or services and prognosis reports must be furnished by the Physician when and as requested by the Fund.
(v) The benefits payable for such services will not exceed the amount which would have been

payable had the services been performed in a Hospital or Convalescent Hospital.

(vi) No payment will be made for services which are custodial in nature, that is, to assist in meeting personal, family and domestic needs.

(vii) No payment will be made unless a plan of home health care or health supportive services treatment is submitted to and approved by the Fund prior to commencing the treatment.

21. <u>Hospice Care.</u> The Plan will pay 100% of Covered Expenses for Respite 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. There is no maximum annual benefit for Non-Respite Hospice care services.

No deductible applies. Covered Expenses shall include only the following items:

(i) Inpatient confinement in a Hospice, for up to a total of 10 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.

(ii) 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) physical, occupational, speech, respiratory or rehabilitation therapy
(d) rental (but not repair or replacement) of durable medical equipment;
(e) laboratory services, medical supplies, oxygen, drugs and medicines prescribed by a Physician; and
(f) nutritional counseling and special meals.

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

(iv) 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. *The Bereavement Period* is the twelve (12) month period that begins on the date of the death of the terminally ill Participant.

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. There is no limit on the number of bereavement counseling sessions.

Covered Expenses (except bereavement counseling) are reimbursed as follows:

Contract Provider	100% of the contracted rates.
Non-Contract Provider	**All Employees (Except Sound & Communication Workers):** 100% of the Scheduled Allowance shown in Appendix A. **Sound and Communication Workers Plan:** 70% of non-PPO Scheduled Allowance.

22. **Hospital Charges.** Hospital charges for preadmission testing.

23. **Hospital Services.**

(i) Daily room and board charges for each day of confinement as a registered inpatient.
(ii) Hospital charges for other medical services and supplies provided during confinement as a registered patient.
(iii) Hospital charges for an Intensive Care Unit when required for the treatment of a critically ill or injured Participant.
(iv) Minimum covered hospitalization for childbirth. Benefits will be extended for hospitalization of a new mother and her newborn infant for at least 48 hours after a normal delivery, and for at least 96 hours after a caesarean section.
(v) An Observation short stay is defined as 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. Any Observation short stay shall not be any more than the Medical/Surgical Per Diem amount in affect at that time. When any observation short stay patient remains in a hospital bed for 24-hours the observation short stay is considered an inpatient stay. For all services rendered after the 24-hours for this type of inpatient confinement, shall be paid at 47% not to exceed the Per Diem amount for any 24-hour Observation stay. All the following days will also be considered at the appropriate inpatient rate.

No benefits will be extended for services related to a normal Pregnancy for a Dependent Child.

24. **Hospital Outpatient Care.** Covered Expenses are Hospital charges for medical services including surgery, and supplies provided during outpatient care.

Contract Hospital	**All Employees (Except Sound and Communication Workers):** 80% of the first $5,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year. **Sound and Communication Workers Plan:** 80% of the first $10,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year.
Non-Contract Hospital	Benefits are payable as described in Appendix A.

25. **Human Papilloma Virus (HPV) Vaccine / Lab Test.** The vaccine and lab test are covered under regular plan benefits.

26. Covered Expenses are the Medically Necessary services and supplies while the Participant is confined in a Hospital as recommended by a Physician. Benefits are payable as follows:

Contract Hospital	**All Employees (Except Sound and Communication Workers):** 80% of the First $5,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year. **Sound and Communication Workers Plan:** 80% of the first $10,000 of Covered Expenses incurred during a calendar year and 100% thereafter for the remainder of the calendar year.

Non-Contract Hospital in and outside of Reno	**All Employees (Except Sound and Communication Workers):** Covered Expenses are limited to the Per Diem fee schedule rate that would have been provided for the same services if provided by the Contract Hospital. Benefits are payable as described in Appendix A. **Sound and Communication Workers Plan:** Covered Expenses are limited to the Per Diem fee schedule rate that would have been provided for the same services if provided by the Contract Hospital. Benefits are payable as described in Appendix A.
Non-Contract Hospitals in and outside of Reno	**All Employees (Except Sound and Communication Workers):** Covered Expenses are limited to the per diem fee schedule rate. Benefits are payable as described in Appendix A. **Sound and Communication Workers Plan:** Covered Expenses are limited to the per diem fee schedule rate. Benefits are payable as described in Appendix A.

NOTE: If hospitalization is required in a Non-Contract Hospital for treatment not offered at the Contract Hospital, Non-Contract Plan benefits will apply.

The Plan provides the following hospital services under Renown Telehealth:

- Pershing General Hospital in Lovelock,
- Mount Grant General Hospital in Hawthorne,
- Battle Mountain General Hospital in Battle Mountain, and
- Grover C. Dils Medical Center in Caliente.

There are times when Renown Health may not have a specialist available for a certain diagnosis in certain rural geographic areas. In that type of situation your Renown healthcare provider or clinic may perform an exam, do necessary diagnostic testing, and connect to another provider or specialist via telemedicine rather than having you travel to that provider. Renown telehealth services are subject to normal Plan benefits and based upon the provider providing the telemedicine services, when initiated through a Renown Telehealth location.

27. <u>Live Organ Donor.</u> Covered Expenses include expenses incurred by a live organ donor, subject to the following:

(i) Donor who is a Participant under this Plan. Regular Plan benefits will apply if the donor is a Participant under the Plan.

(ii) Donor who is not a Participant under this Plan. A maximum benefit payable of $10,000 shall apply to all expenses incurred by a live organ donor if he is not a Participant under this Plan and is without benefit coverage.

28. <u>Mammography.</u> Covered Expenses include:

(i) One baseline mammogram for each female Participant age 35 through 39; and

(ii) An annual routine mammogram for screening or diagnostic purposes for each female Participant age 40 years or older.

29. <u>Medical Supplies and Equipment.</u> Covered Expenses are paid as shown below for the following services:

Contract Provider	According to the contract between the Trust Fund and The Provider limited to Plan benefits.
Non-Contract Provider	Benefits are payable as described in Appendix A.

30. Mental Health Disorders.

Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% of Covered Expenses per calendar year. **Sound and Communication Workers Plan:** 80% of Covered Expenses per calendar year.
Non-Contract Provider	Benefits are payable as described in Appendix A.

Inpatient treatment must be pre-authorized prior to the confinement or as soon as possible.

Contract Provider	Subject to deductible then 80% of the contracted fees.
Non-Contract Provider	**All Employees (Except Sound and Communication Workers):** Subject to deductible then 80% of the non-PPO Scheduled Allowance. **Sound and Communication Workers Plan:** Subject to deductible then 70% of the non-PPO Scheduled Allowance.

31. Organ Transplants. Covered Expenses include charges for the following human to human transplants: cornea, tissue transplant, bone marrow/stem cell, intestine, kidney, heart, lung, heart-lung, liver, and pancreas transplants. However, experimental transplant procedures are excluded from coverage. This Plan also provides separate organ transplant coverage insured through National Union Fire Insurance Company of Pittsburg. Coverage of certain organ transplants is provided without regard to any benefits that may or may not be provided by the major medical plan. For benefit information, pre-authorization of services, and network provider access please contact the Trust Fund Office.

32. Orthotics. Custom molded orthotics are a Covered Expense only when provided by a Doctor of Medicine (M.D.), or a podiatrist (D.P.M.) for treatment of the feet. Expenses for repairs of custom molded orthotics are not a Covered Expense.

33. 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 at 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 handicaps and these will be considered on a case by case basis.

34. Physical Therapist. Services of a registered physical therapist required for the treatment of an acute medical condition as medically necessary.

35. Prescription Drug Benefits (Pharmacy Benefit Management). The Plan has contracted with a Pharmacy Benefit Manager ("PBM") to provide prescription drug benefits for all eligible Participants and their Dependents. Currently the Plan's PBM is with Optum RX. Once eligibility is met you will receive an Identification Card from the PBM. Use this card at any pharmacy participating in the Network

of Pharmacies. Please contact the Trust Fund Office for a list of Network Pharmacies. **NOTE: If you do not show the pharmacy your card for the correct discount, your benefit will be reduced to the Plan allowable amount.**

The Plan pays the applicable 20% in-network coinsurance for retail and specialty drugs (and 20% out-of-network coinsurance up to the Non-PPO allowable amount for all employees except sound & communication workers and 30% out-of-network coinsurance up to the Non-PPO allowable amount for sound & communication workers) directly to the Optum RX pharmacy instead of having the participant pay 100% and getting reimbursed from the Plan.

Benefits will be paid as follows:

(i) Covered charges will be those charges made for drugs and medicine:
- (a) Obtainable only upon the written prescription of a Physician (except for insulin and diabetic supplies) up to a 90-day supply;
- (b) Dispensed by a Licensed Pharmacist; and
- (c) Consistent with the diagnosis and Medically Necessary for the care or treatment of an Injury or Illness.

(ii) No benefits will be payable for the following:
- (a) Multiple and non-therapeutic vitamins;
- (b) Dietary supplements;
- (c) Weight-control items;
- (d) Cosmetics, health and beauty aids;
- (e) Injectable drugs (except insulin);
- (f) Any drug or medicine which is not Medically Necessary for the care and treatment of Injury or Illness; and
- (g) Non-Contract Provider mail order prescription drugs.

Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% coinsurance (Retail); $40 or cost whichever is less (Mail Order Generic Drug); $80 or cost whichever is less (Mail Order Brand or Specialty Drugs). **Sound and Communication Workers Plan:** 80% coinsurance (Retail); $40 or cost whichever is less (Mail Order Generic Drug); $80 or cost whichever is less (Mail Order Preferred Brand or Specialty Drug); $90 or cost whichever is less (Non-Preferred Brand Drug).
Non-Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% of the non-PPO Scheduled Allowance (Retail). **Sound and Communication Workers Plan:** 70% of the non-PPO Scheduled Allowance (Retail).

Please also contact Optum RX for any applicable and available cost sharing coupons for high-cost specialty medications.
Optum RX offers a variable copayment solution that allows participants to sign up for a manufacturer coupon that adjusts the participant's cost share for in-scope medications and applies the coupon value at the point of sale. For more information please contact Optum RX to save on high-cost medications.

36. <u>Prior Authorization/Utilization Review.</u> If a Participant is to be confined in a Hospital on an

elective, non-emergency basis, the Physician must obtain Prior Authorization/Utilization Review by the Trust Fund prior to the confinement. The Trust Fund Office will determine the medical necessity of such Hospital confinement, and if Medically Necessary, the number of authorized days, if any, for the confinement. No benefits are payable for days that are determined not to be Medically Necessary. Prior Authorization/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.

37. **Professional Services.** Covered Expenses are paid as shown below for the following services:

Contract Provider	80%-100% of Contracted Rate limited to Plan benefits.
Non-Contract Provider	Benefits are payable as described in Appendix A.

(i) Services of a Physician for surgery as follows:

(a) Prior Authorization/Utilization Review. Utilization Review by the Trust Fund prior to the surgery is required only if performed in a Hospital or Ambulatory Surgical Facility.

(b) Covered Expenses include surgery or radiotherapy by a primary operating surgeon or assisting surgeon. For the surgeon the primary procedure will be the highest billed dollar amount and will be considered the 1st major procedure, the remaining procedures will follow in the same descending dollar amount in accordance with the Summary Plan Description booklet page 32(f) that describes the required percentage order of payment. Bilateral procedures (Modifier 50) will be cut in half and considered in that dollar amount following the descending dollar order. Surgical procedures that are not subject to this cutback are Add-on Codes or Modifier Exempt codes that are noted in the CPT book.

(c) Benefits for a second Physician or surgeon on the same case at the same time are allowable when the attendance is warranted by a need for supplementary skills. The total value may be increased by 25% in lieu of the assistant's charge. The total value may be apportioned in relation to the responsibility and work done.

(d) When regional or general anesthesia (not including local infiltration anesthesia) is provided by the primary operating or assisting Physician, the amount allowable is determined by the "basic" value for anesthesia without added value for time.

(e) If an incidental procedure (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the benefit will be based on the major procedure only.

(f) When multiple or bilateral surgical procedures, which add significant time or complexity, are performed at the same operative session, the amount allowable will not exceed 100% (full value) for the major procedure, plus 50% of the amount allowable for a second procedure, 25% of the amount allowable for a third procedure, 10% of the amount allowable for a fourth procedure, and 5% of the amount allowable for each successive procedure.

(g) Benefits payable for preoperative care, performance of surgical procedure(s), and/or postoperative care will be based on "Surgery Value Guidelines" as outlined in the 1974 Relative Value Study and as updated from time to time.

(h) Benefits for the services of an assistant surgeon (M.D. assistant) shall be reimbursed up to 20% of the maximum amount allowable for the primary surgeon.

(i) 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 shall be allowed at 15% of the negotiated fees for a Contract Provider or at 15% of the Scheduled Allowance for a Non-Contract Provider.

(j) Surgical trays are considered a separate Covered Expense when used by a Physician for in-office surgical procedures. When the surgery is performed in a facility (inpatient or outpatient), then the surgical tray is considered part of the facility charge.

(ii) Services of a Physician for diagnosis and treatment.
(iii) Services of an anesthetist.
(iv) Services of a registered nurse, except charges made by one who normally resides in the Participant's home or who is the wife, husband, child, brother, sister or parent of the Participant.
(v) Anesthesia and its administration.
(vi) Radiation therapy including the use of radium and radioactive isotopes.
(vii) Services of a licensed outpatient surgical facility. (See Special Outpatient Surgery Benefits)

38. **Routine Prostate Screening.** After satisfaction of the calendar year deductible, a routine prostate specific antigen screening test (PSA) is covered under regular plan benefits.

39. **Routine Pap Smear Examination.** Routine Pap Smear Examination limited to once per year.

40. **Support Hose Stockings.** **Two support hose stockings are covered per calendar year** if it is medical necessary and supported by doctor's orders.

41. **Temporal Mandibular Joint Syndrome ("TMJ").** Benefits are limited to one (1) surgical treatment per year for treatment of medically necessary TMJ, myofascial pain dysfunction syndrome (MPDS), mandibular pain dysfunction (MPD), facial pain and mandibular syndrome, Costen's syndrome, craniocervical mandibular syndrome, and craniofacial pain and dysfunction. Non-Surgical treatments are considered investigational in the treatment of TMJ and are not considered medically necessary treatments and will not be covered under the Plan. Prior authorization is required. Covered TMJ surgical treatment is subject to the Plan's Schedule of Allowances.

42. **Trigger Point Injections**. Trigger point injections are subject to a maximum of 15 visits per calendar year for all Illnesses and Injuries combined. No more than one visit is payable per day and no more than 5 trigger point injections are payable per visit.

Contract Provider	80% of contracted fees
Non-Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% of non-PPO Scheduled Allowance **Sound and Communication Workers Plan:** 70% of non-PPO Scheduled Allowance

43. **Wigs.** Wigs is a covered benefit up to a maximum of $370, if prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of:

(a) Burns resulting in permanent alopecia; or
(b) Lupus; or
(c) Fungal infections not responding to a course of anti-fungal treatment; or
(d) In near or complete cranial hair loss; or
(e) Chemotherapy; or

(f) Radiation Therapy.

44. Transgender Services. Procedures or treatments, including but not limited to breast augmentation, tracheal shave, facial feminization surgery, lipoplasty of the waist, rhinoplasty, face lifts, blepharoplasty, voice modification therapy and surgery, hormonal therapy, for transgender services determined to be medically necessary by a licensed physician will be covered under the Plan for eligible participant and dependent.

45. Lasik Surgery. Effective June 1, 2017, the Plan will cover Lasik Surgery as a medical benefit per eye at $1,500 and $3,000 for both eyes. Lasik Surgery benefits is subject to the applicable medical deductible.

If, as a result of non-occupational accidental injury or illness, a Covered Person incurs eligible medical expenses described in this Article, the Plan shall reimburse and/or pay the designated eligible charge for specified Outpatient and specified Inpatient expenses shown in the "SCHEDULE OF BENEFITS" actually incurred during a calendar year which exceed the amount of the deductible, but not to exceed the maximums specified in the "SCHEDULE OF BENEFITS". The benefits described in this Article are "first-dollar" Basic Medical benefits, subject to the Schedule of Allowance for charges incurred for Medically Necessary treatment of a non-occupational Illness or Injury received by a Non-PPO provider and subject to the Contract rate for the treatment of non-occupational Illness or Injury received by a PPO provider.

46. Autism. A diagnosis of autism is considered a mental health diagnosis and available benefits may include but are not limited to outpatient services such as psychotherapy, physical therapy, Applied Behavioral Analysis (ABA therapy) as well as inpatient treatment if medically necessary. Benefits for autism are payable the same an any other covered illness.

47. COVID-19 Coverage During Public Health Emergency Period.

1. **COVID-19 Testing, Diagnostic Services or Items Coverage.** Effective March 18, 2020, during the declared period of the public health emergency, the Plan will cover charges for the following tests only to detect the SARS-COV-2 or COVID-19 or the diagnosis of the virus that causes COVID-19 (including serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with CARS-COV-2, the virus which causes COVID-19) at no cost (meaning no copayment, deductible or coinsurance) at both an in-network Provider or non-network Provider facilities:
   (a) tests approved, cleared or authorized by the FDA,
   (b) a test that a test developer intends or has requested FDA authorization for emergency use,
   (c) a state authorized test and the state has notified the Department of Health and Human Services, and
   (d) other tests that the Secretary of Health and Human Services determines appropriate in guidance developed during the COVID-19 public health emergency period.

   This COVID-19 coverage extends to any diagnostic services or items provided during a medical visit such as in-person to a doctor's office, urgent care center or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services related to

SARS-COV-2 or COVID-19 testing.

Pricing of Out-of-Network Diagnostic Testing. Per Section 3202 of the CARES Act, the Plan or Insurer will pay or reimburse for covered COVID-19 diagnostic tests as follows: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the diagnostic test provider on the public internet website of such provider.

Preoperative Surgery, Inpatient Admission and Elective Surgery COVID-19 Testing. COVID-19 testing will be covered prior to having medically necessary surgery, inpatient admission and/or elective surgery at no cost to the eligible participant or dependent provided the attending healthcare provider has determined there is a medical necessity for the test, in accordance with accepted standards of current medical practice and subject to the provisions above.

2. **Telehealth and Telemedicine Coverage.** Effective March 6, 2020 and during the period of the declared COVD-19 public health emergency, the Plan will cover, subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, the following virtual services provided by a medical practitioner: (a) telehealth/telemedicine visits (a visit between a medical practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5-10 minute check-in with a medical practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and medical practitioner through an online patient portal). The three (3) foregoing services must be performed consistent with guidelines published by the Centers for Medicare & Medicaid Services ("CMS") in order to be covered (FACT SHEET March 17, 2020). To clarify, medical practitioner is considered an Allied Health Practitioner for purposes of this amendment and the temporary amendment for telehealth/telemedicine coverage does include mental health/substance abuse disorder coverage.

3. **COVID-19 Vaccination and Preventive Services Coverage.**
Effective the earlier of January 1, 2021 or 15 business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations the Plan, through its medical providers and pharmacy benefit manager, throughout the duration of the COVID-19 public health emergency, will cover approved COVID-19 vaccinations and immunizations. Once it becomes available to the public and subject to future government guidance, COVID-19 vaccinations will be available to all eligible participants and dependents at **no cost whether received in-network and out-of-network** and **without prior authorization** at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies through the Optum RX pharmacy benefit manager.

Subject to further government guidance, the cost of the vaccine itself will be covered by the federal government but the cost of the administration of the shots will be covered by the Plan.

For network providers, reimbursement for administration of the shots will be based on the Plan's schedule of allowance or contracted rate with such providers.

For non-network providers (subject to future government guidance), reimbursement for administration of the shots will be based on a reasonable rate such as: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the provider on the public internet website of such provider or the Medicare reimbursement rate.

Providers are prohibited from seeking reimbursement from participants and dependents for the vaccine itself including the vaccine administration costs whether as a cost-sharing or balance billing.

4. Prescription Drug Re-fill During Public Health Emergency. Effective March 23, 2020, during the period of the public health emergency, the Plan's prescription drug early re-fill limits for retail maintenance medications have been extended to allow eligible participants and dependents to re-fill medications early so long as there are refills available with their prescription. There will also be a one-time 90-day supply for specialty medications (versus the traditional 30-day supply). Plan Participants and/or members are encouraged to use the mail order benefit. Exception: Early refills for any controlled prescription medications or opioids will continue to be limited to certain supply limits and require prior authorization request to be received from your prescribing physician. During the pandemic, temporary prescription drug changes will be consistent with Optum Rx's COVID-19 policy (See Optum Rx Notice dated March 20, 2020).

5. COVID-19 Treatment. If a Plan Participant or Dependent is diagnosed with COVID-19, charges for treatment of the COVID-19 virus will be covered in the same manner and subject to the applicable cost-sharing as other medically necessary treatments performed with a network or non-network Provider pursuant to the Plan terms.

ARTICLE IX. COST CONTAINMENT

A. Mandatory Hospital -- Medical Prior Authorization/Utilization Review Program

The purpose of this program is to help you avoid unnecessary hospitalization and to keep costs to a minimum for you and the Plan. The Trust Fund Office is assisting in this program.

Please be aware that the decision to comply with this review program is ultimately up to you. However, if a hospital confinement is determined to be not medically necessary or if you stay longer than the approved number of days, benefits will be denied for days considered not medically necessary.

B. Preadmission Review

Contact the Trust Fund Office in advance of any non-emergency hospital confinement. When your physician/doctor advises hospitalization, it is your responsibility to inform your physician/doctor of the Plan's review program and provide your doctor with the Trust Fund Office telephone number to call in order to comply with the Plan's review requirements. The Trust Fund Office will determine if confinement is needed and, if so, the length of stay necessary. It may be determined that diagnostic testing or a surgical procedure can be safely performed on a less expensive, outpatient basis. Check with your physician/doctor to ensure receipt of your preadmission certification from the Trust Fund Office.

C. Concurrent Review

This portion of the program is designed to make sure that each day you spend in a hospital is medically necessary. After you have been admitted to a hospital, concurrent review takes place at required intervals to determine if continued confinement is necessary. The length of stay your physician proposes will be reviewed, and in most cases the review will confirm that the intended care is appropriate.

In some cases, however, the planned length of stay may appear to be too long. In these cases, the Trust Fund Office may consult with your physician to discuss the case further. If the Trust Fund Office and your physician are unable to agree, you will be informed in writing. In some cases, the employee may be informed after the information is received later from the provider. In some situations, the employee may be informed after the information is received late from the provider. The choice to remain in a hospital is yours but no benefits are payable for the portion of your stay determined to be not medically necessary. Remember, the aim of this program is to provide required care when it is determined medically necessary. By informing you of the Trust Fund Office determination, you are better able to make an informed decision.

D. Emergency Admissions

If you are admitted to a hospital on an emergency basis, have the hospital contact the Trust Fund Office immediately so that concurrent review can begin.

E. Hospital Transfers

If you require a transfer from one hospital to another, the Trust Fund Office must be contacted in advance, unless the transfer is necessitated by a life-threatening emergency. The Trust Fund Office should be contacted as soon as practical after such emergency transfer.

F. Second Surgical Opinion

Second surgical opinions are not mandatory; however, regular Plan benefits are payable for covered expenses in connection with obtaining a second surgical opinion for any covered surgical procedure.

G. Retroactive Authorization

Retroactive Authorization can be done under certain specific circumstances.

ARTICLE X. CONTRACT PROVIDERS: PREFERRED PROVIDER ARRANGEMENTS

A. Preferred Provider Arrangements

The Board of Trustees has entered into a preferred provider arrangement with certain hospitals which entitles you to a discount and will reduce your out-of-pocket expenses when you go to these hospitals. Using a contract hospital will reduce costs for you and the Plan. **A list of preferred providers is**

contained in a separate directory booklet provided by the Trust Fund Office. For this list, please contact the Trust Fund Office.

PLEASE NOTE: Using a Non-contract Hospital will likely result in a greater out-of-pocket expense for you. **Contact the Trust Fund Office for current information and refer to the booklet provided by the Trust Fund Office.**

In addition, preferred provider arrangements have been made with a number of local pharmacies and health-care providers, including physicians, pediatricians, ophthalmologists, optometrists, specialists, anesthesiologists, diagnostic and laboratory facilities, home health care providers, inpatient facilities, durable equipment suppliers and outpatient surgery facilities. When you use a preferred provider, the charge will be discounted, or in some cases will be payable at as much as 100% (with no deductible), depending on the preferred provider arrangement.

With Preferred Providers available, you can save yourself and the Plan money by selecting Preferred Providers whenever you need medical, dental, or vision care. Please note that your Network is in a constant state of change and New Providers may enter the Network. Before services are rendered, please verify the Preferred Provider status by calling the Healthcare Services Department at the Trust Fund Office, **1-775-826-7200,** before making an appointment with a provider you have not seen before or to verify that a current PPO contract is still in effect. **It is your responsibility to verify that your choice of provider and/or location of office and/or facility are in fact a Preferred Provider. Failure to do so may result in reduced benefits and higher out-of-pocket expenses to you.**

You are encouraged to take advantage of the savings offered by these Preferred Providers. Contact the Trust Fund Office at (775)-826-7200 or email www.skerr.bpa@sbcglobal.net for the current Preferred Providers and the percentages payable for using each.

In addition to any exclusion and limitations described elsewhere in this booklet, the following Exclusions and General Limitations are applicable to all Benefits provided under this Plan.

B. NO Plan Benefits and/or Payments are extended for any of the following: **Please also refer to Article XI. Below for additional exclusions not covered by the Plan.**

1. No Eligibility. Care, treatment or services for which, regardless of the Participant's and/or Dependent's financial ability, there is no legal obligation of the Participant and/or Dependent to pay or for which no charge is made in the absence of eligibility for Benefits.

2. Government Institutions. Care, treatment or services which are furnished under any governmental institution or agency except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. 629.

3. Other Benefits. Expenses incurred which may be paid under any other Benefit provided by the Fund.

4. Government Services. Any services provided by a local, state or federal government agency, or any services for which payment may be obtained from any other local, state or federal government agency.

5. Other Policy or Plan. Expenses incurred for which benefits are provided under any other group insurance policy, other medical benefits or service plan, union welfare plan or employee benefit plan for which an employer directly or indirectly makes contributions or payroll deductions.

6. **War, Crimes, Illegal Acts, Special Circumstances**. Expenses due to or resulting from: (1) Illness or Injury that is intentionally self-inflicted, while sane or insane, unless the injury resulted from an act of domestic violence or a mental health condition such as depression (2) war, act of war, armed invasion or aggression, (3) nontherapeutic release of nuclear energy, or (4) a Participant committing or attempting to commit a felony or while engaging in the commission of a crime (no conviction is required). Exclusion does not apply to terms 1 and 4, when such illness or injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

7. **Work-Related Injuries.** Expenses relating to any Illness or Injury for which benefits of any nature are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, employer's liability law, or occupational disease law, even if a Participant fails to claim their right to such benefits. Benefits may be advanced while a claim is pursued if a Participant assigns to the Plan all rights to medical reimbursement under such laws.

If a claim is settled or compromised such that the Plan is reimbursed in an amount less than the amount of the Plan's proper lien claims or results in the carrier being relieved of future liability for medical costs, no further Benefits are payable by the Plan in connection with the Illness or Injury forming the basis of the claim. However, the Trustees or their duly authorized representative in its capacity may determine the claim to be one which is not unreasonable from the Plan's standpoint.

8. **Not Medically Necessary/ Experimental/Others.** Expenses incurred for: (1) services that are not Medically Necessary, or (2) Experimental Treatment, drugs or research studies, or (3) any fees in excess of the Scheduled Allowance or discounted fees, or (4) any services or supplies not recommended by a Physician, or (5) any services or supplies not considered legal in the U.S.

9. **Cosmetic Surgery.** Cosmetic Surgery or other services for beautification, except for a) repair of accidental damage caused by Injury within one year of an accident, or b) reconstructive surgery following a mastectomy. "Cosmetic Surgery" means surgery to change the shape or structure of (or otherwise alter a portion of) the body, performed solely or primarily for the purpose of improving appearance and not as a result of Illness or Injury which requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery during or following mutilative surgery required as a result of Illness or Injury shall not be considered Cosmetic Surgery.

10. **Services by a Non-Physician or a Relative or Member of Household.** Services furnished by (i) a Naturopath or any other provider not meeting the definition of Physician or Allied Health Professional, or (ii) charges made by a Relative of the Participant or a member of the Participant's household.

11. **Rest Homes.** Custodial or domiciliary care or rest cures, care in a home for the aged, nursing, convalescent, or rest home or institution of a similar character, or custodial services in the home, except as specifically provided under the Hospice Care Benefit or Home Health Care Benefit.

12. **Pre-Eligibility Services.** Services rendered or supplies furnished prior to becoming eligible or after eligibility is terminated. An expense is considered incurred on the date the Participant receives the service for which the charge is made.

13. **Certain Childhood Expenses**. Expenses in connection with hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorder, mental retardation, or autistic disease of childhood.

14. **Health Clinic/Fitness or Exercise Center.** Services, equipment or membership fees associated with health clubs or related fitness or exercise centers.

15. **Pools/Spas/Saunas/Whirlpool/Hot tubs**. Expenses incurred for pools, spas, saunas, whirlpool, Jacuzzi or hot tub devises, exercise equipment, air purifiers or conditioners or other similar devices, food supplements or substitutes, or supplies for comfort, hygiene or beautification.

16. **Hearing Devices.** Expenses incurred for hearing devices or the fitting of hearing devices unless otherwise provided for in the Plan rules.

17. **Certain Devices**. Expenses for replacement or repair of prosthetic devices or durable medical equipment, orthopedic shoes (except when joined to braces) or shoe inserts.

18. **Artificial Conception.** Conception by artificial means including (but not limited to) artificial insemination, in vitro fertilization, ovum transplants, embryo transfers, the cost of donor semen, reversal of voluntarily surgically induced sterilization procedures, and other infertility-related services or supplies.

19. **Obesity and Other Items**. Expenses incurred and services provided for: (1) weight reduction or treatment of obesity, (2) educational services, (3) nutritional counseling, (4) baldness or hair removal, (5) hypnotism, (6) biofeedback, (7) stress management, (8) pain control, and (9) any other goal oriented behavior modification therapy except for medically necessary bariatric surgery as provided for under the Plan rules

20. **Physical Exams.** Expenses for any examinations required for obtaining or maintaining employment, insurance or governmental licensing, school or sporting activities. Coronary scoring CT scan will be covered at 80% not subject to deducible and charges from a Non-PPO provider are subject to 80% coinsurance and any amounts over the scheduled allowance.

21. **Immunizations for Travel.** Expenses for immunizations required solely for travel outside the United States.

22. **Certain Newborn Care.** This Plan complies with federal law that prohibits a plan from requiring a health care practitioner to obtain authorization to prescribe a hospitalization in connection with childbirth to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.

23. **Excess of Annual Maximums for Non-Essential Health Benefits**. Amounts in excess of any permitted limits placed on non-Essential health Benefits.

24. **Sex Changes.** Expenses related to sexual reassignment, procedures or treatments designed to alter physical characteristics to those of the opposite sex, or any resulting medical complications.

25. **Elective Abortion.** Expenses in connection with an elective termination of pregnancy, except (1) where the life of the mother is at risk or (2) medical complications arising from elective termination of pregnancy.

26. **Vision-Related Items**. Eyeglasses, contact lenses, optometric services, vision therapy including orthoptics (except for estropia, exotropia or strabismus), routine eye examinations, eye refractions for the fitting of glasses, or radial keratotomy, except as provided under Vision Care Benefits.

27. **Modification to Home or Vehicles.** Expenses incurred for modifications to your home, property, or vehicles regardless of their therapeutic or ease-of-access value, including without limitation, elevators, ramps, stairs or car hand controls.

28. **Speech or Occupational Therapy.** Speech therapy or occupational therapy, except rehabilitation treatment following a stroke or Injury. If an occupational therapist performs otherwise covered physical therapy, it will be covered under the Plan's physical therapy benefit.

29. **Myofunctional Therapy.** Myofunctional therapy.

30. **Surrogate Pregnancy.** Treatment related to a Surrogate Pregnancy in which the Participant and/or Dependent Spouse act as Surrogate in a surrogate pregnancy is excluded. This exclusion applies to any and all costs related in any way to the surrogate pregnancy, including delivery costs. This Exclusion also applies to any and all complications related to the surrogate pregnancy.

31. **Temporomandibular Joint Dysfunction (TMJ).** Non-Covered procedures and services for the diagnosis of Temporomandibular Joint Dysfunction (TMJ) or disturbances of the temporomandibular joint except as provided for under the Plan rules.

32. **More than one home or office visit by a physician or an allied health care professional or telephone consultations between you and your physician.**

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

ARTICLE XI. GENERAL EXCLUSIONS, LIMITATIONS, AND REDUCTIONS

Not every medical, dental, vision, and prescription drug service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician. This Plan covers only those services and supplies that are medically necessary. Please also refer to Article X.B. above for additional exclusions not covered under the Plan. The Plan shall not provide benefits for the following except to the extent listed under the Plan or any subsequent Amendment to the Plan:

1. Any charges in excess of the Schedule of Allowance.

2. Charges for Items or Services not specifically listed as or are not determined to be Covered Expenses, including any charge in excess of the benefit, dollar, day, visit or supply limits stated in this Plan booklet.

3. Expenses incurred for services that are not Medically Necessary, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary.

4. Experimental or investigational treatment.

5. Services for which the Participant is not legally obligated to pay or for which no charge is made to the Participant. Services for which no charge is made to the Participant in the absence of insurance or other indemnity coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

(a) It must be internationally known as being devoted mainly to medical research;

(b) At least ten percent of its yearly budget must be spent on research not directly related to patient care;

(c) At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

(d) It must accept patients who are unable to pay; and

(e) Two-thirds of its patients must have conditions directly related to the Hospital's research.

6. Except to the extent benefits are required by Federal law to be provided by the Plan, any services provided by a local, state or federal government agency, or any services for which payment may be obtained from any such agency.

7. Occupational injury or sickness, including injury or sickness eligible for payment under a worker's compensation law whether or not the employer has elected to provide such coverage. This exclusion also applies to injuries incurred while self-employed provided, however, that if the right to recover such benefits is disputed, the Fund will provide benefits in accordance with the Plan upon condition that the Participant sign an agreement with the Fund to prosecute a claim arising out of or in the course of employment diligently, consent to the allowance to the Fund of a lien against his/her compensation for the benefits it provides and otherwise cooperate with the Fund, and any person or agency designated by the Fund, in securing reimbursement for the benefits so provided.

8. Conditions caused by or arising out of an act of war (declared or not) armed invasion or aggression.

9. Services furnished by a naturopath or any other provider not meeting the definition of Physician or Allied Health Practitioner.

10. Charges made by (a) a relative of a Participant, or (b) a member of a Participant's household.

11. Custodial care or rest cures or Long-Term Care. Services provided by a rest home, at Participant's home, a home for the aged, a private duty nursing home or any similar facility (except as provided for under the Plan and medically necessary).

12. Hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit disorder, mental retardation or autistic disease of childhood, or for outpatient psychotherapy and psychological testing, except as specifically provided in the Plan.

13. Services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except tumors or cysts, or as specifically provided on page 50, Dental Care Benefits.

14. Surgery to correct refractive error.

15. Treatment solely for cosmetic purposes or other services for beautification (such as plastic surgery) are not eligible expense, except:

(a) to correct congenital anomalies;

(b) to correct a functional disorder;
(c) as a result of Injury; or
(d) as provided in Article XXV, Women's Health and Cancer Rights Act of 1998.

16. Orthopedic shoes (except when joined to braces) or shoe inserts except custom molded orthotics as described under Medical Supplies and Equipment, #7; air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification.

17. Services for which benefits are payable under any other programs provided by the Plan.

18. Educational services, nutritional counseling or food supplements or substitutes, except for the Diabetes Instruction Program as outlined in Article XIV, Section D.

19. Speech therapy or occupational therapy (except rehabilitation treatment following a stroke or Injury), or myofunctional therapy.

20. Services to reverse voluntary surgically induced infertility; invitro fertilization, or other infertility related services.

21. Elective abortions except:
(a) where the life of the mother would be endangered if the fetus were carried to term; or
(b) for complications of an abortion.

22. Hypnotism, stress management, services for weight loss, and any goal-oriented behavior modification therapy, such as to quit smoking, lose weight, or control pain except as specifically provided by the Plan.

23. Routine physical examination or examinations except those provided under Preventive Care Benefits as described in the Summary of Benefits.

24. Intentional, self-inflicted injuries. This does not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition, including physical and mental health conditions (such as depression) and the Plan will not require history of a physical or mental health condition in its record before approving a claim for payment of medically necessary treatment for injuries incurred during an attempted suicide.

25. Accidents or Illness incurred during the commission of or attempt to commit a misdemeanor or a felony, illegal act, aggravated assault or occupation. This exception does not apply to charges for injuries sustained by a victim of an act of domestic violence, provided the charges are otherwise covered under the Plan.

26. Prosthetic services or devices ordered or prescribed prior to the date an individual becomes eligible for benefits under the Plan.

27. Immunizations and flu shots except where covered by the Plan.

28. Well Child Care except when covered by the Plan.
29. Treatment for conductive hearing loss is not an eligible expense, except:
(a) to correct congenital anomalies;
(b) to correct a functional disorder;

(c) as a result of injury; or
(d) as provided in Article XIV, Section D. Hearing Aids.

30. Treatment Related to a Surrogate Pregnancy in which the Participant and/or Dependent acts as the Surrogate in a surrogate pregnancy. This exclusion applies to any and all costs related in any way to the surrogate pregnancy, including delivery costs. This Exclusion also applies if there is a miscarriage or other complications related to the surrogate pregnancy.

31. Non-Emergency care when traveling outside of the United States.

32. Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the Plan and expenses incurred after termination of eligibility under the Plan.

33. Routine foot care.

34. Dual Coverage of Participant Electrician Spouses. If two employees are lawfully married to each other and are both participants under the Plan, the Plan will coordinate the benefits of such participant.

35. Midwife services are not a covered benefit under the Plan.

36. Non-listed Expenses. Services not specifically listed in this Plan as Covered Expenses.

ARTICLE XII. VISION CARE BENEFITS

A. GENERAL

The Plan offers vision care benefits under a self-funded arrangement. However, the vision benefits are considered an excepted benefit not subject to the Affordable Care Act mandates and not an integral part of the group health plan. Please contact the Trust Fund Office if you are electing not to receiving vision coverage benefits for yourself and/or your eligible Dependent(s). Vision Care Benefits are subject to the terms and conditions hereafter stated and in accordance with the Schedule of Benefits as shown below:

1. Eye examination. Limited to one examination per calendar year.

2. Vision Coverage. For Adult Participants, one (1) pair of eyeglasses, including single, bifocal, trifocal or lenticular lenses if an examination indicates a necessary change in lenses and frames, once per calendar year; or one (1) contact purchase per calendar year. For Dependent Child(ren) under Age 19, one (1) pair of eyeglasses once per calendar year; or one (1) contact purchase per calendar year.

3. Necessary Contact Lenses. Necessary contact lenses once furnished under the Plan shall be replaced, but in no event more frequently that once each calendar year and are subject to the following conditions:

(a) Must follow cataract surgery;
(b) To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
(c) Anisometropia, a difference in the refractive power of the two eyes; or
(d) Keratoconus, conical protrusion of the cornea.

4. **Contact lenses for cosmetic purposes**. Not to exceed the amount shown below in the "Schedule of Benefits" (in lieu of lenses and frames only).

B. ANNUAL LIMITS

1. Adult Participants/Dependents. Adult Participants and Dependent Child(ren) Age 19 or older are subject to the Vision Care Benefit limits under the Schedule of Benefits below.

2. Pediatric Dependent Children. There is no calendar year maximum on Vision Care Benefits for Dependent Child(ren) under Age 19.

C. SCHEDULE OF BENEFITS

The Plan will reimburse Participants and/or their eligible Dependents or Providers up to the following amounts:

	Adult Participants & Dependent Child(ren) Age 19 and Older	**Pediatric Dependent child(ren) Under Age 19**
Contract Provider	100% of negotiated fees	100% of negotiated fees (No Annual Limit)
Non-Contract Provider	Up to the following allowances: Exam $40.00 Single Vision $36.00 Bifocal lenses $55.00 Trifocal lenses $70.00 Lenticular $150.00 Frames $35.00 Photo/Tint (Employee) $20.00 Tint Rose #1 or #2 (Dependent) $7.00 Contact Lenses (Necessary) $225.00 Contact Lenses (Cosmetic) $96.00 Bifocal Contact Lenses $123.00	100% of fee schedule (No Annual Limit)

D. LIMITATIONS

The Participant and/or eligible Dependent is responsible for any additional costs above the amounts

shown above for:

1. Oversize lenses;
2. Multi-focal plastic lenses;
3. Blended lenses; or
4. Coated Lenses.
5. Frame Allowance

E. EXCLUSIONS

No Vision Care Benefits are provided for the following:

1. Orthoptics or vision training; plano (non-prescription) lenses; glasses secured when replacement is not deemed necessary; or a second pair of glasses in lieu of bifocals.
2. Non-prescription sunglasses.
3. Lenses and Frames furnished under this program which are lost or broken cannot be replaced except at normal intervals when services are otherwise available.
4. Medical or Surgical treatment of the eye.
5. Services or materials provided arising out of the course of employment, or services which can be obtained without cost from any federal, state, or local organization, or agency.
6. Any eye examination required by an employer.

ARTICLE XIII. DENTAL CARE BENEFITS

A. DENTAL BENEFITS

The Plan offers dental and certain orthodontic care benefits under a self-funded arrangement. However, the dental and orthodontic related benefits are considered an excepted benefit not subject to the Affordable Care Act mandates and not an integral part of the group health plan. Please contact the Trust Fund Office if you are electing not to receive dental coverage benefits for yourself and/or your eligible Dependent(s). If a Participant undergoes a dental examination or dental treatment by a Dentist or a dental hygienist under the supervision of a Dentist, the Plan will, subject to the provisions hereafter stated, pay the coinsurance percentage up to a calendar year maximum payment of $3,000 per Adult Participant (including Dependent Children age 19 or older). There is no calendar year maximum on dental benefits for Dependent Children under age 19.

Contract Provider	90% of contracted fees
Non-Contract Provider	80% up to the Scheduled Allowance

If a Participant undergoes orthodontic treatment, the Plan will, subject to the provisions hereafter stated, pay the coinsurance percentage up to a lifetime maximum of $1,500 each for the Active Employee and Spouse, and $2,500 for each eligible dependent child. Paid at 80% of the Scheduled Allowance.

B. COVERED DENTAL SERVICES

Covered services include:

1. Preventive Dental Services.

(a) A complete mouth survey or panoramic x-ray once every thirty-six (36) months. Benefits shall be limited to one complete mouth survey x-ray or one panoramic x-ray, but not both.

(b) Bitewing x-rays two times per calendar year.

(c) Two fluoride treatments per calendar year for a person to age 14 years.

(d) Two prophylaxis treatments and two oral examinations during any one calendar year.

(e) One sealant treatment per calendar year for a person to age 14 years on molars with no prior restorations on the molar teeth.

2. Oral Surgery. Extraction and other dental surgery including pre- and post-operative care.

3. **Anesthesia**. Local and general anesthesia when administered by a dentist for a covered oral surgery procedure or as determined by the plan.

4. **Restorations**. Treatment of tooth decay or fracture with amalgam, resin-based composite. When teeth cannot be restored with these materials, gold restorations, crowns, and jackets will be allowed. Benefits shall be limited to one crown per tooth once every 5 years.

5. Endodontics. Pulpal therapy, orthodontic therapy, root canal filling (treatment of non-vital teeth), re-treatment of previous root canal therapy and treatment of root canal obstruction.

6. Periodontics. Treatment of gums and bones supporting the teeth, periodontal scaling and root planning, periodontal maintenance and osseous surgery.

7. Prosthodontic Services.

(a) Removable – including full and partial dentures, bridges, reline/rebase services and repairs.

(b) Fixed – including bridge pontics, abutments (inlays and crowns), repairs, and recement bridges.

(c) Prosthodontic services will be covered once every five years.

8. Dental implants (materials implanted into or on bone or soft tissue), the removal of implants, and the services and supplies Medically Necessary for such procedures.

9. Night guards, for treatment of Bruxism only

10. If a filling is not adequate then an inlay or onlay will be covered in place of a crown within a 5-year replacement limitation.

C. ORTHODONTIC CARE EXCLUSIONS SERVICES

Orthodontic care benefits will **not** be paid for the following:

1. 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
2. Orthodontic treatment that will require major restorative dental work not ordinarily performed in general dentistry
3. Replacement of lost or broken appliances or retainers.

D. DENTAL EXCLUSIONS AND LIMITATIONS

The Plan will **not** pay for the following:

1. Any services or supplies for which Participant is entitled to benefits arising out of or in the course of employment; or
2. Treatment of an injury which arises out of or in the course of employment; or
4. Any prosthetic device (including bridges and crowns) and the fitting thereof which was ordered before the Participant became eligible; or
5. The performance of any procedure rendered principally to improve the appearance of the Participant; or
6. More than two prophylaxis treatments during any calendar year; or
7. Replacement of an existing partial or full removable denture or fixed bridgework more often than once every five years unless (a) such replacement is made necessary by the initial placement of an opposing full denture or the extraction of natural teeth, or (b) the denture or bridgework is temporary and is being replaced by a permanent denture or bridgework, or (c) the denture or bridgework, while in the oral cavity, has been damaged beyond repair as a result of Injury; or
8. All diagnosis, treatment, and repair to the teeth or gums for disease or Injury related to tumors.
9. Charges for general anesthesia and the outpatient surgical facility for children under the age of 6 that require services outpatient and not in the Dentist office, will not be covered under the dental benefits. Please see medical benefits for limited covered services in Article XIV; or
10. Charges made by (a) relative of a Participant, or (b) member of a Participant's household.

E. EXTENSION OF DENTAL BENEFITS

In the event of termination of eligibility, benefits will be provided in accordance with the provisions shown in Section B above for covered dental expenses incurred within 30 days following the date of termination for only prosthetic services rendered or prosthetic devices furnished in connection with a dental procedure which began prior to the date eligibility terminated.

F. DENTAL SUPPLY

The Plan will cover materials used for or in conjunction with the replacement or repair of the teeth or gums including but not limited to prosthetic devices.

ARTICLE XIV. DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT

A. LIFE INSURANCE BENEFITS (FOR EMPLOYEES ONLY)

The Life Insurance benefits are available to Active Full-time (defined as working 30 hours per week) employees only. Dependents are not eligible for Life Insurance benefits. Those making self-payments under COBRA are not eligible for this benefit.

1. **SUMMARY OF LIFE INSURANCE BENEFIT.** The Plan provides $5,000 of Group Term Life Insurance. (24-hour coverage).

2. LIFE INSURANCE EFFECTIVE DATE. Your Life Insurance becomes effective on the date you qualify for group health and welfare benefits.

3. WHEN LIFE INSURANCE ENDS. Your Life Insurance automatically ends on the earliest of the following dates:

(i) The date the last period ends for which a required premium is made on your behalf by the Electrical Workers Health and Welfare Plan for Northern Nevada; or

(ii) The date the group policy terminates, or a specific benefit terminates; or

(iii) The date you cease to be eligible for the Plan due to the lack of employer, or a combination of employer and employee contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits WILL NOT serve to extend your Life Insurance benefits; or

(iv) The last day of the month in which you cease to be Actively-at-Work, unless:

a. Active work ceases during an approved layoff, medical leave or non-medical leave of absence, the Life Insurance Benefit and the Accidental Death & Dismemberment Benefit will continue for up to 3 months from the date you stopped active work; and
b. Active work ceases as a result of a disability due to a sickness or accidental injury and:
    (i) that disability began before age 65; and
    (ii) the Covered Person remains continuously disabled.

4. WAIVER OF PREMIUM (TOTAL DISABILITY). Life Insurance will continue without premium payment while you are totally disabled if:

a. You become totally disabled while insured under the group policy prior to age sixty-five (65);

b. You remain totally disabled continuously for at least nine (9) consecutive months;

c. Satisfactory proof of total disability is furnished to the insurance company; and

d. Such proof is submitted to the insurance company no later than twelve (12) months after you become totally disabled. The insurance company may at any time require proof that Total Disability continues. You must give proof within 60 days after the insurance company's request. After you have been Totally Disabled for more than two years from the date of Total Disability, the insurance company will not request proof nay more than once a year.

For purposes of this section, "**Totally Disabled**" or "**Total Disability**" means that, as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material and substantial duties of any gainful occupation for which you are reasonably fitted by training, education or experience. The insurance company may require you to be examined by a Physician, other Medical Practitioner or Vocational Expert of its choice. If requested, the insurance company will pay for your examination.

Premium payment must continue to be made during the first one-hundred and eighty (180) days of

total disability. If you qualify for the Waiver of Premium Benefit, those premiums will be refunded to the Trust. Premium Benefits are waived on a monthly basis, beginning on the first day of the month after the month you become Totally Disabled. The insurance company will not refund premiums for any period more than 12 months before the date proof of disability was furnished. This Waiver of Premium will continue to be effective even if the Policy terminates after you become Totally Disabled.

The amount of Life Insurance continued under the Waiver of Premium Benefit will be the amount of your Life Insurance in effect on the day preceding total disability. If you receive an Accelerated Benefit, the Life Insurance amount will be reduced according to the Accelerated Benefit provision.

Death While Totally Disabled. If you die while your Life Insurance is being continued under Waiver of Premium, the insurance company will pay the amount of insurance if it receives proof:

(i) Of your death; and
(ii) Total Disability was continuous from the date it began to the date of death.

Termination of Total Disability Benefit. All insurance under this Waiver of Premium Benefit will end on the earliest of:

(i) The date that you are no longer totally disabled. However, if you are still eligible for Life Insurance when you return to Active Work, your Life Insurance may be continued in force if premium payments are resumed. If this is done, any increased amount of life Insurance you may then be eligible for will take effect as follows:

a. Policy anniversary date on or next following the date of the increase, if you are actively at work on the date of increase; or
b. Date you return to Active Work if you are not actively at work on the policy anniversary date on or next following the date of the increase;
c. Policy anniversary date on or next following the date of the increase, if the policy anniversary date is a non-working day and you were Actively at Work on your last scheduled working day before the non-working day; or
d. Policy anniversary date on or next following the date of the increase if you are on an approved layoff or leave of absence, for reasons other than a sickness or injury; or

(ii) Sixty (60) days after the date the insurance company mails a request for additional proof of total disability, if satisfactory proof is not given; or

(iii) The date you fail to attend an examination or cooperate with the examiner;

(iv) The effective date of an individual Life Insurance policy, if you have converted under Right to Convert; or

(v) The date you attain age sixty-five (65); or
(vi) The date premium has been waived for 12 months and you are considered to reside outside the United States. You are considered to reside outside the United States when you have been outside the United States for a total period of 6 months or more during any 12 consecutive months for which premium has been waived.

5. LIFE INSURANCE EXCLUSIONS. No life insurance benefit is payable if the loss is caused

or contributed to by any of the following:

(i) Suicide or other intentionally self-inflicted injury, while sane or insane.

(ii) Committing or attempting to commit assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at a scene of a violent disorder or riot while performing your official duties.

6. RIGHT TO CONVERT. Without submitting evidence of insurability and if you apply in writing and pay first premium during the conversion period (which is the 31 days after your Life Insurance ends), you may convert:

(i) All or part of your life insurance to an individual policy, other than term insurance, if your insurance terminated because you cease to be eligible for the Plan; or

(ii) The amount of insurance to an individual policy, other than term insurance, that is lost due to a reduction of insurance for any reason; or

(iii) A limited amount of insurance to an individual policy, other than term insurance, if you have been continuously insured under the policy for five years and your insurance terminated due to termination or amendment of the policy. In such case, the amount you may convert is the smaller of the following:

a. Amount of life insurance which terminates, less the amount you became eligible for under any policy within 31 days after your insurance terminated; or

b. $10,000.

Also, if your Total Disability ends and you do not return to Active Work, then you may exercise your right to convert to an individual policy of Life Insurance.

7. THE INDIVIDUAL POLICY. You may select any form of individual Life Insurance policy the insurance company issues to persons of your age, except:

(i) A term insurance policy;

(ii) A universal life policy;

(iii) A policy with disability, accidental death, or other additional benefits; or

(iv) A policy in an amount less than the minimum amount the insurance company issues for the form of Life Insurance you select.

The individual policy of Life Insurance will become effective on the later of: (1) its date of issue; or (2) 31 days after the date the insurance terminates. If you die during the conversion period, the insurance company will pay a death benefit equal to the maximum amount you had a Right to Convert, whether or not you applied for an individual policy. The benefit will be paid according to the Benefit Payment and Beneficiary Provisions.

8. CLAIMS

(i) Filing a Claim

Claims should be filed on the insurance company's form. You may obtain a claim form by contacting the Trust Fund Office. Proof of Loss must be provided within ninety (90) days after the date of the loss. If that is not possible, it must be provided as soon as reasonable possible, but not later than one (1) year after that ninety (90) day period. Proof of Loss for Waiver of Premium must be provided within eighteen (18) months after the date of total

disability. Further Proof of Loss will be required at reasonable intervals, but not more often than once a year after you have been continuously disabled for two years.

(ii) Proof of Loss

Means written proof that a loss occurred: 1) For which the group policy provides benefits; 2) Which is not subject to any exclusions; and 3) Which meets all other conditions for benefits. Proof of Loss includes any other information which may reasonably be required in support of a claim. Proof of Loss must be in writing and must be provided at the expense of the claimant. No benefits will be provided until the insurance company receives Proof of Loss.

(iii) Notice of Decision on Claim

Your beneficiary will receive a written decision on a claim within a reasonable time (not to exceed 90 days) after the claim is received. If special circumstances require an extension of time for processing the claim, written notice of the extension will be provided prior to the expiration of the initial 90-day period. If the beneficiary does not receive the insurance company's decision within ninety (90) days after they receive the claim (or if an extension was required, 180 days), the beneficiary will have an immediate right to request a review as if the claim had been denied. If the claim is denied (in whole or in part), the beneficiary will receive a written notice of denial containing:

(a) The reasons for the decision;
(b) Reference to the parts of the group policy on which the decision is based;
(c) A description of any additional material or information needed to support the claim, if the claim was denied because the claimant failed to provide all necessary information, and an explanation of why such material or information is necessary; and
(d) Information concerning the beneficiaries' right to a review of the decision.

(iv) Review Procedure of Denied Claims and Complaint Procedure

The Beneficiary may contact the insurance company's service representative in an attempt to resolve the complaint in an informal manner. If the beneficiary is not satisfied with any attempts at information resolution, the beneficiary must follow the review of denied claims procedure outlined below.

If all or part of a claim is denied, the beneficiary must request a review in writing within sixty (60) days to the address identified in the claim denial letter, after receiving notice of the denial. The beneficiary may send the insurance company written comments or other items to support the claim and may review any non-privileged information that relates to the request for review. The insurance company will review the claim promptly after receiving the request. They will send notice of their decision within sixty (60) days after receiving the request or notice of a complaint, or within one-hundred and twenty (120) days if special circumstances require an extension. If special circumstances require such an extension of time, written notice of the extension shall be furnished to the beneficiary prior to the expiration of the initial 60-day period. The written notice of the final decision will state the reasons for their decision and refer to the relevant parts of the group policy on which the decision is based.

9. BENEFIT PAYMENT AND BENEFICIARY PROVISIONS.

(i) Payment of Benefits

Benefits payable because of your death will be paid to the beneficiary you name. Beneficiary means a person you name to receive any amount of insurance payable due to your death.

(i) Naming a Beneficiary

(a) You may name one or more beneficiaries. Two or more surviving beneficiaries will share equally, unless you specify otherwise. You may name or change beneficiaries at any time without the consent of a beneficiary. You must name or change beneficiaries in writing. Your beneficiary designation:
   (i) Must be dated and signed by you;
   (ii) Must be delivered to the Plan Administrators, during your lifetime;
   (iii) Must relate to the insurance provided under the group policy; and
   (iv) Will take effect on the date it is delivered to the Plan Administrators.

(b) You may obtain a beneficiary designation form by calling the Plan Administrators. The Plan Administrator's address and telephone number are listed in the General Information section of this benefit booklet described on page 1.

(ii) Simultaneous Death Provision

If a beneficiary dies on the same day you die, or within 15 days thereafter, benefits will be paid as if that beneficiary had died before you, unless proof of loss with respect to your death is delivered to the insurance company before the date of the beneficiary's death.

(iii) No Surviving Beneficiary

If you do not name a beneficiary, or if you are not survived by one, benefits will be paid in equal shares to the first surviving class of the classes below:
   a. Your spouse,
   b. Your natural or legally adopted child(ren),
   c. Your parent(s),
   d. Your brother(s) and sister(s); and
   e. Your estate.

10. ALLOCATION OF AUTHORITY. The insurance company has full and exclusive authority to control and manage the group policy, to administer claims, and to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

11. TIME LIMITS ON LEGAL ACTIONS. No action at law or in equity may be brought until sixty (60) days after the insurance company has been given proof of loss. No such action may be brought more than three (3) years after the earlier of: The date the insurance company receives proof of loss and the time within which proof of loss is required to be given.

12. ASSIGNMENT. The rights and benefits under the Group Policy cannot be assigned.

13. ADDRESS AND TELEPHONE NUMBER. The address and telephone number of the insurance companies can be found in the General Information section (see page 2).

B. ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE – For Employees Only

Accidental Death and Dismemberment insurance benefits are available to active full-time employees only. Dependents are not eligible for Accidental Death and Dismemberment insurance benefits. Those making self-payments under COBRA are not eligible for this benefit. Accidental Death and Dismemberment insurance is provided through a contract with the insurance company.

1. SUMMARY OF ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE BENEFIT

Accidental Death and Dismemberment insurance (AD&D) provides benefits for dismemberment or death resulting from accidental bodily injuries. The Accidental Death and Dismemberment insurance benefit is summarized below.

2. WHEN BENEFITS ARE PAYABLE

If you have an accident while insured for AD&D insurance, and the accident results in a loss, the insurance company will pay benefits according to the terms of the group policy after satisfactory proof of loss is received. Proof of loss must be provided to show:

(i) Injury occurred while the insurance was in force;
(ii) Loss occurred within 90 days after the injury; and
(iii) Loss was due to injury independent of all other causes.

3. Definition of Loss for AD&D Insurance

Loss means loss of life, hand, foot or sight, which:

(i) Is caused solely and directly by an accident;
(ii) Occurs independently of all other causes; and
(iii) Occurs within 365 days after the accident.

Specific definitions are as follows:

1. With respect to a **hand or foot**, loss means actual and permanent severance from the body at or above the wrist or ankle joint.
2. With respect to **sight**, loss means entire and irrevocable loss of sight.
3. With respect to a **thumb and index finger**, loss means the actual, complete and permanent severance through or above the metacarpophalangeal joints.
4. With respect to **speech or hearing**, loss means the total and irrevocable loss of speech or hearing.
5. **Quadriplegia** means total and permanent paralysis of both upper and lower limbs.
6. **Paraplegia** means total and permanent paralysis of both lower limbs.
7. **Hemiplegia** means total and permanent paralysis of upper and lower limbs on one side of the body.
8. **Paralysis** means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an injury to the brain or spinal cord and without the severance of a limb.

4. Amount Payable

The amount payable is equal to a percentage of your AD&D insurance in effect on the date of the accident. Your AD&D insurance is $5,000. The amount payable is as follows:

Loss	Amount
Life	**$5,000**

One hand, thumb and index finger of same hand, one foot,	**$2,500 or sight of one eye**
Both hands, both feet, sight of both eyes or the loss of any one	**$5,000 two of these**
Speech or hearing	**$1,250**
Quadriplegia	**$5,000**
Paraplegia	**$2,500**
Hemiplegia	**$2,500**

No more than 100% of your AD&D insurance will be paid for all losses resulting from one accident.

Seat Belt and Air Bag Benefit. An additional Seat Belt benefit is payable for a loss of your life that results from injuries sustained while driving or riding in a private passenger car if your seat belt was properly fastened. Also, an additional Air Bag benefit is payable if:

1. Seat Belt Benefit is payable; and
2. Private Passenger Car is equipped with a single Air Bag and you are the driver; or
3. Private Passenger Car is equipped with an Air Bag for both the driver and for the front passenger seat and you are the driver or front passenger; or
4. Private Passenger Car is equipped with an Air Bag for the driver seat, for the front passenger seat and for all rear passenger seats and you are the driver, front seat passenger or rear seat passenger, and
5. Policy report or other evidence established that the Air Bag inflated properly upon impact.

The accident causing the death must occur while you are insured under the group policy. The amount payable is as follows:

1. 10% of the full amount of AD&D benefit; or
2. 10% of the full amount for the Seat Belt Benefit or $20,000 for the combined Seat Belt and Air Bag Benefit.

5. <u>AD&D Insurance Exclusions</u>

No AD&D insurance benefit is payable if the Loss is caused directly or indirectly by any of the following:

1. War or act of war declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

2. Suicide or other intentionally self-inflicted injury, while sane or insane.

3. Committing or attempting to commit assault or felony, or actively participating in a violent disorder or riot. Actively participating does not include being at a scene of a violent disorder or riot while performing your official duties.

4. The voluntary use or consumption of any poison, chemical compound or drug, unless used or consumed according to the directions of a physician.

5. Sickness, disease, bodily or mental infirmity, or pregnancy existing at the time of the accident.

6. Heart attack or stroke.

7. Driving while intoxicated, as defined by the applicable State law where the loss occurred.

8. Engaging in the following hazardous activities, including skydiving, hang gliding, auto racing, mountain climbing, Russian roulette, autoerotic asphyxiation or bungee jumping.

9. Injury arising out of or in the course of any occupation or employment for pay or profit, or any Injury or Sickness for which you are entitled to benefits under a Workers Compensation Law, Employers Liability Law or Similar Law, unless this insurance is issued on a 24 hour basis.

10. Travel or flight in, or descent from any aircraft unless as a fare-paying passenger on a commercial airline flying between established airports on: (a) a scheduled route, or (b) a charter flight seating 15 or more people.

11. Medical or surgical treatment for any of the above.

6. When AD&D Insurance Becomes Effective

Your AD&D insurance becomes effective on the date you qualify for group health and welfare benefits.

7. When AD&D Insurance Ends

Your AD&D insurance automatically ends on the earliest of:

1. The date the last period ends for which a required premium is made on your behalf by the Electrical Workers Health and Welfare Plan for Northern Nevada; or

2. The date the group policy terminates, or a specific benefit terminates; or

3. The date you cease to be eligible for benefits by the Plan as a result of employer or a combination of employer and employee contributions for the health and welfare benefits. A self-payment under COBRA to continue health and welfare benefits will not serve to extend your AD&D insurance benefit; or

4. The date you no longer qualify for group health and welfare benefits; or

5. The last day of the month in which you cease to be Actively-at-Work, unless:

a. Active work ceases during an approved layoff, medical leave or non-medical leave of absence, the Life Insurance Benefit and the Accidental Death & Dismemberment Benefit will continue for up to 3 months from the date you stopped active work; and

b. Active work ceases as a result of a disability due to a sickness or accidental injury and:

(i) that disability began before age 65; and

(ii) the Covered Person remains continuously disabled.

8. CLAIMS LIFE AND AD&D

(i) Filing a Claim for Benefits

Claims should be filed on the insurance company claim forms. You may obtain a claim form by calling the Trust Fund Office, whose address and telephone number are listed in the General Information section of this Benefit Booklet (see page 2).

(ii) Time Limit for Filing Proof of Loss

See the provisions for the Insured Death Benefit above.

(iii) Proof of Loss

See the provisions for the Insured Death Benefit above.

(iv) Notice of Decision on Claim

See the provisions for the Insured Death Benefit above.

(v) Review Procedure

See the provisions for the Insured Death Benefit above.

9. BENEFIT PAYMENT AND BENEFICIARY PROVISIONS

See the provisions for the Insured Death Benefit above.

10. ALLOCATION OF AUTHORITY

The insurance company has full and exclusive authority to control and manage the group policy to administer claims, and to interpret the group policy and resolve all questions arising in the administration, interpretation and application of the group policy.

11. TIME LIMITS ON LEGAL ACTIONS

See the provisions for the Insured Death Benefit above.

12. ASSIGNMENT

The rights and benefits under the group policy cannot be assigned.

ARTICLE XV. GENERAL PROVISIONS

A. NO ASSIGNMENT OF BENEFITS - The benefits payable hereunder shall not be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge or garnishment. There is no assignment of benefits to providers and no benefit payments may be paid to providers.

B. TIME TO FILE CLAIMS - Benefits shall be paid by the Plan only if notice of a claim is made within one hundred eighty (180) days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as required by the Board of Trustees. Any submission of claims later than one hundred and eighty (180) days are subject to the approval of the Board of Trustees, but in no event shall claims be considered for payment later than twelve (12) months from the date on which covered charges were incurred.

C. INCOMPETENCE OR INCAPACITY - If the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt with no appointed guardian, or in the event the Covered Person has not provided the Plan with a current address the Plan may pay any amounts otherwise payable to the Covered Person to the Covered Person's spouse, blood relative, or any other person or institution determined to be equitably entitled to payment. In the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with this provision shall discharge the Plan and the Trustees hereunder to the extent of such payment.

D. NO RIGHT TO BENEFITS - No Covered Person or other beneficiary shall have any right or claim to

benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereto shall be resolved by the Board of Trustees. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees. No such action may be brought unless brought within one year after date of such decision. The decision of the Board of Trustees shall be final and binding on all parties.

E. WORKERS COMPENSATION INSURANCE - The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

F. CONTROL DOCUMENTS - The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

G. AVAILABLE ASSETS FOR BENEFITS - The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in the Collective Bargaining Agreement. In the event that the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer to make benefit payments or contributions (other than the contributions for which the contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

H. FUND PHYSICIAN - The Fund, at its own expense, shall have the right and opportunity to have a physician of its choice examine the Covered Person when and as often as it may reasonably require to resolve any claim at issue.

I. TRUSTEE RIGHTS - To carry out its obligation to maintain, within the limits of the funds available, a sound economic program dedicated to providing the benefits for Covered Persons, the Board of Trustees expressly reserves the right, in its sole discretion:

1. to terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects the claims in process and/or expenses already incurred; or

2. to alter or postpone the method of payment of any benefit; or

3. to amend any provision of this Plan Document.

J. THIRD PARTY RECOVERY/SUBROGATION/REIMBURSEMENT REQUIREMENTS - If the Covered Person is injured through the act or omission of another party, Plan benefits are available provided all of the following are met:

1. The Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation

on the part of that third party.

You are required to notify the Trust Fund Office if any claims you incur under the Plan are the result of an accident, injury, disease or other condition for which a third party is OR MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

Charges incurred by a Participant or Dependent for which a Third Party is responsible are not covered charges under any benefits provided in this Plan. However, payments will be advanced to an otherwise eligible participant or beneficiary, if the conditions of this section are met.

2. The Covered Person (Participant, Spouse, Child or Other dependent) agrees to pay to the Plan immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family insurance coverage.) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Covered Person who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent of the payments made by the Plan.

3. The Plan may require that any Covered Person complete an Accident Questionnaire Form and execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. An equitable lien attaches to any benefits advanced by the Plan on behalf of any Covered Person regardless of whether an Agreement to Reimburse and/or Assignment of Recovery is completed and returned to the Trust Fund. **Any Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds. The Participant is liable for any amounts not paid by a spouse or child or other covered person.**

4. The Plan is entitled to a first priority and first-dollar basis recovery for the full amount of Covered Charge it has paid or may pay for the injury or illness of a Covered Person that are related to the Third Party Claim from any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the 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.

5. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall come first and are not adversely impacted in any way by: (a) the extent to which the Covered Person recovers his/her full damages and/or attorneys' fees; or (b) how such recovery may be itemized, structured, allocated, denominated, or characterized; e.g., without regard to any characterization as a recovery for such matters as lost wages, damages, attorneys' fees, etc. rather than for medical expenses, the type of property or the source of the recovery, including any recovery from the payment or compromise of a claim (including an insurance claim), a judgment or settlement of a lawsuit, resolution through any alternative dispute resolution process (including arbitration), or any insurance (including insurance on the Covered Person, no-fault insurance, or uninsured and/or underinsured motorist coverage).

6. Such reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits. Without in any way limiting the

preceding, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Covered Person has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Covered Person claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Covered Person may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

7. The Plan's right to subrogation, reimbursement, restitution, to a lien, and as a beneficiary of a constructive trust shall in no way be affected, reduced, compromised, or eliminated by any doctrines limiting its right (equitable or otherwise, whether established at any other federal or state common law or statute) such as the make-whole doctrine, collateral source, contributory or comparative negligence, the common fund doctrine, or any other defense.

8. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Covered Person against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent. The Plan's claim shall be a lien on said recovery and attach to the recovery or any tangible property that the recovery may be transmuted to. The Covered Person also agrees that until such lien is completely satisfied, the holder of any such property (whether the Covered Person, his/her attorney, an account or trust set up for the Covered Person's benefit, an insurer, or any other holder) shall hold such property as the Plan's constructive trustee. As such, the constructive trustee agrees to immediately pay over such property to or on behalf of the Plan pursuant to its direction to the extent necessary to satisfy the equitable lien.

9. If the Covered Person does not attempt to recover benefits paid by the Fund or for which the Fund may be obligated, the Plan shall, if in the Plan and Participants' best interest and at its sole discretion, be entitled to institute legal action or claim against the responsible parties, against any uninsured or underinsured insurance coverage, or against any other first-party or third-party contract or claim in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to the Covered Person or paid on their behalf.

10. The Covered Person shall immediately notify the Trust upon receiving a judgment, settlement offer or other compromise offer and upon filing any petition to compromise a minor's claim. The Covered Person shall not settle or compromise any claims with the Trust's consent.

11. If the Covered Person settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust.

12. The Trust may cease advancing benefits if there is a possible basis to determine that the Covered Person will not honor the terms of this section. If the Covered Person does not reimburse the Plan or otherwise comply with the obligations under this section, the Plan may take all appropriate steps to recover money it pad on his/her behalf of for his/her dependents, including filing suit against the Covered Person and/o**r offsetting (including refusing to honor) any future claims incurred by the Participant and/or his or her family members against amounts owed to the Plan.**

K. ERISA - The Plan of benefits created herein is an "Employee Welfare Plan" under the Employee Retirement Income Security Act of 1974 as amended.

L. PARTICIPANT ON ACTIVE MILITARY SERVICE:

1. Military Duty**.** If a Participant is called to active military duty for a period of 30 days or longer, the Participant may elect either of the following options:

    a. to have his/her Reserve Hour Bank frozen as of the first day of the month following the commencement of active service, which will terminate all eligibility for the Employee and any dependents; or
    b. to continue the eligibility of the Employee's dependents using the Employee's Reserve Hour Bank, until it is depleted (and then be eligible to pay a premium for COBRA).

2. Eligibility Rules for USERRA. To qualify for re-employment rights under the Uniformed Service Employees Reemployment Rights Act ("USERRA"), including certain limited health care benefits (summarized below), a Covered Employee must meet the following requirements:

    a. Purpose of Leave. The employee had to leave civilian employment for the purpose of entering a "uniformed service." Uniformed services includes the Army, Navy, Air Force, Marine Corp, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency.

    b. Employee Provide Prior Notice of Service. An employee leaving for uniformed service has to provide prior notice that his/her absence will be due to uniformed service. Written notice is not required. You are strongly urged to notify the Union Dispatch Office so that the uniformed service may be noted on the dispatch rolls, your employer, and the Trust Fund Office so the Plan is aware of your situation.

    c. Assert Military Rights for no More than Five Years (with certain exceptions). You may assert USERRA benefits for military absence not to exceed five years. There are limited exceptions to the five-year rule so if you are close to that period, you may contact the Trust Fund Office to determine if your situation may meet an exception to the five-year rule.

    d. Employee Must be Honorably Discharged from Service. The employee must have been honorably discharged from the military service.

    e. Return to Covered Employment within a Specified Period. You must return to your same employer or another employer that contributes to the Plan within a specified period, depending upon the length of time you are absent for military service. The rules for return to employment are:

        (1). Service of Less than 31 Days. If your period of military service is less than 31 days, you must be available for Covered Employment on the next calendar day (so long as you had at eight hours rest after returning home by normal transportation methods) following the end of service.

(2). Service of More than 30 and Less than 181 Days. If your military service lasts longer than 30 days but less than 181 days, you must be available for Covered Employment no later than 14 days after completion of military service.

(3). Service of More than 180 Days. If your leave from Covered Employment for military service exceeds 180 days, you must be available for Covered Employment no later than 90 days after you have completed your military service.

3. Right to Certain Health Care Benefits Under the Plan

a. Less than 31 Days of Service-One Month of Free Coverage. If you are absent from Covered Employment for less than 31 days, you may elect to continue your coverage with the Plan at the expense of the Plan.

b. Absent for More than 30 Days. If you are absent from Covered Employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). After that first 30 days, you will be required to pay a premium of 102% of the Plan's cost of the coverage. Typical rights under COBRA are for 18 months, rather than the longer 24-month periods for veterans. USERRA's continuation requirements are similar but not identical to COBRA's requirements. Your absence for service in the uniformed services will trigger rights under both statutes, and you are entitled to protection under the law that provides the most favorable benefit.

c. Hour Bank Frozen if so Requested. Unless you request otherwise, your Hour Bank under the Plan will be frozen effective with the first of the month following the month that eligibility will be provided from your last hours of employment before entering the service. For example, if you last worked January, you will have your Hour Bank frozen as of March, with coverage for April provided at the Plan's expense. If you wish to continue coverage for up to the additional 23 months after April, you may then do so by electing and paying COBRA-like payments to the Plan Office. After you return to Covered Employment (with proper notice and documentation), your Hour Bank will be reinstated in accordance with the Plan rules.

d. Twenty-Four Months of Continuation Coverage. The Participant and/or any Dependents will be eligible to pay for Continuation Coverage for up to 24 consecutive months. Coverage under the Participant's Hour Bank will recommence after discharge from active military duty if the Employee returns to work for a contributing Employer or becomes available to work for a contributing Employer as shown by registration on the Union's out-of-work list provided the Employee returns to work or registers within 90 days of discharge.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS, a federal health care plan. The Participants should review these coverage's before making a decision to self-pay.

YOU MUST NOTIFY THE TRUST FUND OFFICE OF YOUR RETURN FROM ACTIVE DUTY. Participants must notify the Plan Office of their return from active duty. The

Plan Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

Right to Waive your Rights. However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members. The months of coverage so applied.

M. PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 [HIPAA]

1. INTRODUCTION.

The Plan is required by state and federal law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information, known as Protected Health Information ("PHI") that identifies you is kept private and secure to the extent required by law. We are also required to give you this Notice regarding the uses and disclosures of medical information that may be made by the Plan, and your rights and the Plan's legal duties with respect to such information. The Plan must also follow the duties and privacy practices described in this Notice. This Notice and its contents are intended to conform to the requirements of HIPAA, and it applies to all records containing your PHI that are created, transmitted or retained by the Plan or Business Associates (including their subcontractors) that help administer the Plan.

- **PHI Defined.** The term "PHI" or "medical information" in this Notice means individually identifiable medical and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.
- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.
- **Minimum Necessary.** When using or disclosing PHI, 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 factors and limitations and any applicable law requiring greater disclosure.

The Plan office will also let you know promptly if a breach occurs that may have compromised the privacy or security of your information. The Plan will not use or share your information other than as permitted by HIPAA and unless you tell the Plan Office it can in writing. If you tell the Plan office it can, you may change your mind at any time, but let the Plan Office know in writing.

The rights in this Notice apply to you, your Spouse, and your Dependents.

Please be advised that other vendors or entities that provide medical, dental and vision services to you related your participation in the Plan have issued or may issue you a separate Notice regarding disclose of PHI that is maintained by those entities.

2. For more information please see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. POTENTIAL IMPACT OF STATE LAWS.

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example,

where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

3. BOARD OF TRUSTEES' OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION

The Board of Trustees Will:

a. Prohibit Use and Disclosure of Protected Health Information. Not use or disclose your Protected Health Information except as permitted by the benefit booklet as amended from time to time or required by law.

b. Subcontractors and Agents. Ensure that any agent or subcontractor to whom the Board of Trustees provides your Protected Health Information agree to the restrictions and conditions in the benefit booklet including this section, with respect to your Protected Health Information.

c. Permitted Purposes. Not use or disclose your Protected Health Information for employment-related actions or decisions in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.

d. Reporting. Report to the Plan's privacy officer any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.

e. Access to Protected Health Information by Participants. Make your Protected Health Information available to you in accordance with 45 C.F.R. § 164.524.

f. Amendment of Protected Health Information. Make your Protected Health Information available for amendment and, upon request, amend your Protected Health Information in accordance with 45 C.F.R. § 164.526.

g. Accounting of Protected Health Information Disclosures. Track disclosures made of your Protected Health Information so that an accounting of disclosures can be made available to you upon request in accordance with 45 C.F.R. § 164.528.

h. Disclosure to Governmental Agencies. Make available the Plan's internal practices, books and records relating to the use and disclosure of your Protected Health Information to the United States Department of Health and Human Services to determine compliance with 45 C.F.R. § 164.

i. Return or Destruction of Protected Health Information. When your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, the Board of Trustees must, if feasible, return to the Plan, or destroy, all Protected Health Information that the Board of Trustees received from or on behalf of the Plan.

This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Board of Trustees agrees to restrict, and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

j. Minimum Necessary Requests. Use their best efforts to request only the minimum necessary type and amount of your Protected Health Information to carry out the functions for which the information is requested.

4. ADEQUATE SEPARATION BETWEEN THE TRUSTEES AND THE PLAN

The Board of Trustees represent that adequate separation exists between the Plan and the Board of Trustees so that Protected Health Information relating to the payment, health care operations or other matters pertaining to the Plan:

- Employees of Trust Fund Office; and
- Business Associates of the Plan and their employees, officers, directors, agents and subcontractors

provided the Business Associate has signed a Business Associate Agreement.

The person and organizations identified above will have access to your Protected Health Information only to perform plan administration functions. The persons and organizations identified above will be subject to disciplinary action and sanctions, including termination of the contract for any use or disclosure or your Protected Health Information in breach or violation of the Business Associate Agreement.

5. ADEQUATE SEPARATION CERTIFICATE

The Board of Trustees represents that the employees and organizations identified above are the only employees and organizations who will access and use your Protected Health Information generated by the Plan. The employees and organizations identified above will only access and use your Protected Health Information for the purposes identified in the section titled *"DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE BOARD OF TRUSTEES".*

6. Privacy Practices of the Northern Nevada Electrical Workers Health and Welfare Plan

How do we typically use or share your medical information?

The following categories describe different ways that we use and disclose medical information. For each category of uses and disclosures, the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information may fall within one of the categories.

Treatment.	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. *Example: Doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
For Payment.	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. *Example: We share your eligibility for benefits information with Anthem Blue Cross to confirm whether payment will be made for a particular service.*
For Health Care Operations/Appeals.	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal.

	Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.
As Required by Law.	The Plan can use and disclose your health information if required by state, federal or local laws. *Example: We share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues.	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability. *Example: We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits.	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. *Example: We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*
Disclosure to Health Plan Sponsor & IBEW Local Unions.	Medical information may be disclosed to the Plan Sponsors, i.e. IBEW Local 401, and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.
Organ and Tissue Donation.	The Plan can share health information about you with organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
Military, Veterans, and Inmates.	The Plan may release health information about you as required by military command authorities, if you are a member of the armed forces, or to a correctional institute or law enforcement official, if you are an inmate or under custody of a law enforcement official.
Respond to Lawsuits and Disputes.	Th The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. *Example: We receive a discovery request in which you are a party involved in a lawsuit.*
Government or Law Enforcement Requests.	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement official or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims. *Example: We release health information because there is suspicion that your death was the result of a criminal conduct, or because of civil administrative or criminal investigations, audits, inspections, licensure or disciplinary action, or other activities necessary for the government to monitor government programs (such as Medicare fraud review), or for special*

	government functions such as military, national security and presidential protective services.
Research.	The Plan can use and share your health information for health research subject to certain conditions.
Child Immunization Proof to Schools.	The Plan may disclose proof of immunization of a student to the School, prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian, or student of consenting age. Consent may be given by e-mail, in writing, over the phone, or in person.
Decedent's Health Information.	The Plan may disclose your PHI to your family members and others who were involved in your care or payment of your care, unless doing so is inconsistent with your prior written expressed wishes that was given to the Plan. However, PHI of persons who are deceased for more than 50 years is not protected under the HIPAA privacy and security rules. *Example: We disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death.*
Business Associates & Subcontractors.	The Plan may also share your PHI with business associates, including its subcontractors or agents that perform certain administrative services for the Plan. As required by federal law, the Plan has a written contract with each of its business associates that contains provisions requiring them to protect the confidentiality of your PHI and to not use or disclose your PHI other than as permitted by the contract or as permitted by law.

Our Uses and Disclosures

For certain information, you can tell us your choices we Share.

Except as provided for in this Notice or as permitted by law, the Plan will not release your PHI without your written authorization. **If you have a clear preference for how the Plan shares your information in the situations described below, contact the Plan office and tell the Plan what you want the Plan to do. The Plan Office has an Authorization Form that you may sign to authorize release of all or part of your PHI.**

In these cases below, you have both the right and choice to tell the Plan to:

- ✓ Share information with your family, close friends, or others involved in your health care or payment for your case, as long as you do not object.
- ✓ Share information in a disaster relief situation.

If you are not able to tell the Plan your preference, for instance if you are unconscious or not around, the Plan may share your health information if the Plan believes it is in your best interest. The Plan may also share your health information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Plan will not share your information unless you give your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- ✓ **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- ✓ **Marketing Authorization**. The Plan cannot receive financial remuneration (direct or indirect payment) from third parties in exchange for the marketing of PHI unless permitted under HIPAA or with your prior written authorization. Marketing is any communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This Plan never markets personal information.
- ✓ **Sale of PHI.** The Plan is prohibited from directly or indirectly receiving financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell your PHI.
- ✓ **Fundraising Purposes**. Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. Although the Plan does not use nor does it intend to use your PHI for fundraising purposes, it must inform you of your right to opt out of receiving any fundraising communications (whether received in writing or over the phone) if it uses or discloses your PHI for fundraising purposes.
- ✓ **Genetic Information.** Your PHI includes genetic information. In regard to underwriting, which is premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008. Also, the Plan cannot use your genetic information to decide whether it will give you coverage and the price of that coverage.
- ✓ **Other Uses of Medical Information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of your responsibilities to help you.

- ✓ **Right to Inspect and Copy Your Medical Information.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site 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 deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical

information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

- ✓ **Right to Amend/Correct Your Medical Information.** If you feel that medical information, we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment or correction for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. 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 health information.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

- ✓ **Right to an Accounting of Disclosures.** You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures other than disclosures made to carry out treatment, payment or health care operations, to individuals about their own medical information, incident to an otherwise permitted use or disclosure, pursuant to an authorization, for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, as part of a limited data set, and for other national security or to correctional institutions or law enforcement officials.

  To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site 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 deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- ✓ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- ✓ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example,

you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us you would be in danger if the Plan office does not honor your request. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

- ✓ **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- ✓ **Right to Provide an Authorization**. As noted above, the Plan may request your written authorization for uses and disclosures that are not identified by this Notice or permitted by law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing.

- ✓ **Right to a File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Plan Office by contacting the Privacy Officer listed on the last page or with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling (877) 696-6775, or **visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**. You must file a complaint within 180 days after the occurrence of the event or violation. You may also contact the Privacy Officer if you have any questions or concerns regarding your Privacy rights or regarding the specifics of filing a complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint and the Plan will not retaliate against you for filing a complaint.

- ✓ **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice).** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

- ✓ **Right to Restrict Disclosure of PHI If Paying Out-of-pocket.** If you paid for services out-of-pocket, in full, for a specific item or service, you have the right to ask your Health Care Provider to not disclose your PHI related to that item or service to the Plan for purposes of payment of health care operations. The Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

- ✓ **Right to Choose Someone to Act For You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your health information or be allowed to take any action for you. The Plan Office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

Changes to This Notice

We can change this Notice, and the changes will apply to all information we have about you. Any changes that may occur, we will mail the revised Notice to participants. The New Notice will be available upon request (at any time), on our website, and we will mail a copy to you. The Plan will comply with the terms of any such Notice currently in effect.

Requests for Information

Questions regarding this information (and requests for the right to inspect and copy, the right to correct or amend and the right to an accounting of PHI) should be addressed to the HIPAA Privacy Officer at:

Electrical Workers Health and Welfare Plan for Northern Nevada
c/o Benefit Plan Administrators
445 Apple Street
Reno, Nevada 89502
Telephone: (775) 826-7200

N. FAMILY MEDICAL LEAVE ACT--EMPLOYEES OF LARGER EMPLOYERS:

Certain large Employers (has at least 50 employees) may have to continue to pay for your health coverage during an approved leave under the federal or state Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

a. Your Employer has at least 50 Employees;
b. You must be actively employed by a contributing employer at the time you take FMLA;
b. You worked for one or more contributing Employers for at least 12 months (not consecutive) and for a total of at least 1,250 hours during the most recent 12 months before the FMLA; and
c. You require leave for one of the following reasons:

i. birth (within one year of birth) or placement of a child for adoption or foster care (within one year of placement),
ii. to care for your child, spouse or parent with a serious medical condition, or
iii. your own serious health condition,
iv. Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). Care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness;
v. if you are unable to work or telework due to the care of your son or daughter because of the closure of the child's school or place of care or the unavailability of a childcare provider due a public health emergency which is defined as an emergency with respect to COVID-19 declared by a Federal, State or local authority (during the period of April 1, 2020 through December 31, 2020); or
vi. Any other purpose provided for by the FMLA as amended.

You must intend to return to work for your employer after the FMLA and you may use the FMLA benefit

once per 12 consecutive months. Details concerning FMLA leave are available from your Employer. If you are requesting Emergency Expanded FMLA leave during April 1, 2020 through December 31, 2020, please contact your employer regarding taking Emergency Expanded FMLA leave.

Requests for FMLA leave must be directed to your Employer; the Plan Office cannot determine whether you qualify. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Your Employer is the one who will certify your eligibility for FMLA health care continuation. If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments to the Plan. If the dispute is resolved in your favor, and your Employer makes the required contributions, the Plan will refund the corresponding COBRA payments to you. If your Employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the Employer for contributions made for your coverage during the leave.

O. QUALIFIED MEDICAL CHILD SUPPORT ORDERS/NATIONAL MEDICAL SUPPORT NOTICES

The Plan will recognize a Qualified Medical Child Support Order (QMSCO) and enroll as directed by the Order any covered child of an Employee specified by the Order. A Qualified Medical Child Support Order is any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

(a) provides the child of a Plan Participant with child support or directs the Participant to provide the child with coverage under a health benefits plan, or

(b) 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 parent does not enroll the child, then the non-Employee parent or State agency may enroll the child.

A QMCSO may be either a National Medical Child Support Notice ("NMSN") issued by a state child support agency or an order or a judgment from a state court or administrative body directing the employer/plan to cover a child under the Plan. Federal law requires that a medical child support order meet certain form and content requirements in order to be qualified. You may request a copy of the written procedure for determining whether a medical child support order is qualified, free of charge, from the Trust Fund Office. In general, the following steps will be followed to establish and determine whether a court order or NMSN will qualify as a QMCSO:

(a) The participant must provide the Trust Fund Office with a copy of the court order or NMSN and/or QMCSO;
(b) Within 30 days of receipt of the QMCSO and/or NMSN, the Trust Fund office or the Plan's Legal Counsel will notify the Participant in writing if the order is acceptable to the Plan;
(c) If the Plan determines the court order or NMSN and/or QMCSO is not acceptable or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's Legal Counsel;
(d) **If a QMCSO and/or NMSN is denied**. The notice will describe the reasons for denial and your right to appeal, along with a summary of the Plan's appeal procedures. In most instances however, you will simply be asked to revise the order in such a way that it is a

QMCSO and/or qualified NMSN.

(e) **If additional information is required**. The notice will describe what is needed. There will be sixty (60) days to respond.

(f) To be Qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such 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.

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/her custodial parent or legal guardian if so required by the Medical Child Support Order.

No eligible Participant's child covered by a Qualified Medical Child Support Order 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.

A QMCSO recognizes an eligible Child(ren)'s right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The Child(ren) must meet the Plan requirements of an eligible Dependent Child(ren) and will be covered through age 25. **Coverage may terminate earlier than age 26 if the QMCSO and/or NMSN states such.**

The Plan and its delegates have the discretion to enroll the child(ren) using its best judgment in the interpretation of a QMCSO and/or NMSN.

P. THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans generally may not, under Federal law, 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 cesarean delivery.

Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). Furthermore, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96-hour as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

Q. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Your health plan, 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 repigmentation 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).

Call the Trust Fund Office for more information.

R. CHANGES ALLOWED UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

The Children's Health Insurance Program Reauthorization Act of 2009 created a new special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit those eligible for group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or SCHIP coverage or
- Become eligible to participate in a premium assistance program under Medicaid or SCHIP

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SHIP or the eligibility determination.

S. CLAIM FORMS

All claims for benefits shall be filed on forms provided by the Trust Fund Office, which will be available from the Plan Office. The Plan, upon receipt of a written notice of claim, will furnish such forms to the claimants.

T. PROOF OF LOSS

Written proof of loss must be furnished to the Trust Fund Office for any claim of benefits payable under the Plan, other than Death or Prescription Drug Benefit, within 180 days after the beginning date of such loss. A proof of loss shall be considered to have been furnished as soon as a claim is received at the Trust Fund Office, provided the claim is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as possible of what is necessary to complete the claim. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if the Trustees determine it was not reasonably possible to give proof within such time, provided, except in the absence of the claimant's legal capacity, it is later than one year from the time proof is otherwise required.

U. PAYMENT OF CLAIMS

Subject to any written direction of the Participant in an application or otherwise, all or a portion of any benefits provided by the Plan on account of hospital, medical or surgical services may, at the Plan's option, and unless the claimant requests otherwise in writing, no later than the time for filing proof of

such loss, be paid directly to the Hospital or individual rendering such services.

Amounts payable for other than Death Benefits will be paid to the claimant subject to the provisions set forth in this section, or if the claimant is deceased, to the claimant's beneficiary.

V. PHYSICAL EXAMINATION

The Plan, at its own expense, has the right and opportunity to have a physician or provider of its choice examine the person of any individual whose injury or sickness is the basis of a claim, when and as often as it may reasonably require during the continuance of a claim under the Plan.

W. CONSTRUCTION

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of Nevada. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

X. NO VESTED RIGHT

Nothing in this Plan shall be construed as giving Employees, retired or terminated, dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time.

Y. FACILITY OF PAYMENT

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor or, if there is no such guardian, to such adult or adults as have complied with the requirements of Nevada or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

Z. AVAILABLE ASSETS FOR BENEFITS

Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to such payments. No contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as required in the collective bargaining agreement.

In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer or any IBEW Local to make benefit payments or contributions in order to provide for the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

AA. GENDER AND NUMBER

Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

BB. OVERPAYMENTS; DUTY OF COOPERATION

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

If an overpayment of benefits has been made to or on behalf of the employee or dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, including benefit payments due on behalf of another covered family member, and/or institute legal action to collect the overpayment and related costs and attorney's fees and interest.

You and your covered dependents must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims and/or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred, and other damages related to that over-payment.

A claim for benefits will be rejected and the Fund will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

CC. PATIENT PROTECTION AND AFFORDABLE CARE ACT ("ACA")

1. **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 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 limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit ***www. Healthcare.gov/glossary/essential-health-benefits.)***

   Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the 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.

2. **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 for Plan Years beginning after January 1, 2014. 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.

3. **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.

4. **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.

5. **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.

6. **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.

7. **Prohibition on 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.

8. **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.

DD. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA).

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) 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. Pursuant to the Final 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.

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 issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa*.

ARTICLE XVI. COORDINATION OF BENEFITS (COB)

All benefits of this Plan are subject to Coordination of Benefits (COB) and benefits are coordinated when you and your spouse (and/or your dependent children) are eligible for benefits from both this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim. COB payment amounts shall not exceed the contracted maximums of the contract providers. At no time will the Plan pay more than for what the Participant is financially responsible.

A. PURPOSE - The intent of this Article is to guarantee that the amount of benefits paid under this Plan plus the amounts of benefits paid under all other plans shall not exceed the actual cost charged for a treatment or service.

1. COB Claims. Benefits are coordinated on all employee, retiree and dependent claims. COB applies only to medical, prescription drug and dental benefits—it does not apply to vision benefits, Life Insurance, AD&D Insurance or Weekly Disability Benefits.

2. Sharing of Information. The Fund Office may release or receive necessary information about your claim to or from other sources. You must furnish the Fund Office with any information it needs to process your claim.

3. Claim Filing Requirement. You must file a claim for any benefits you are entitled to from any other source. Regardless of whether you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).

4. Other Group Plans. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield plans, motor vehicle insurance, and blanket insurance plans. If you or your spouse are covered under another plan, you can contact the Plan Office to find out whether that plan fits the definition of a group plan.

5. Medicare. Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A and Part B of Medicare, even if he has not actually enrolled in both Parts. (See Section 13.05 for more detail.)

6. File Claims with Other Plans Too. When anyone in your family is covered under another group health plan and has a claim, be sure that you file claims with all eligible plans and provide all required information about other coverage on all claim forms.

7. Failure to Take Action. If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan, but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.

8. Auto Insurance and Other Policies. In the event a covered person is eligible for benefits under this Plan as well as under other group or individual fault or no-fault automobile insurance policies, this Plan's benefits will coordinate with those under the automobile insurance policies, so that the total benefits be paid under all policies do not exceed 100% of the total allowable expenses actually incurred. In all cases where a covered person is eligible for receipt of benefits under a no-fault automobile insurance policy, the automobile insurance carrier will be primary.

B. DEFINITIONS

1. **COORDINATION** - shall mean benefits are paid so that no more than 100% of the Network Allowance shall be covered under the combined benefits from all of the plans shown in paragraph 2 below.

2. **PLAN** - shall mean any medical expense benefits provided under:

   a. any insured or non-insured group, service, prepayment, or other program arranged through an Employer, Trustee, union, or association; or

   b. any program required or established by state or federal law (including Medicare Parts A and B); or

   c. any program sponsored by or arranged through a school or other educational agency; and the first

party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent or any minimum benefits required by law except that the term Plan shall not include benefits provided under a student accident policy or any individual policy, nor shall the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

The term Plan shall apply separately to those parts of any program that contain provisions for coordination of benefits with other plans and separately to those parts of any program that do not contain such provisions.

3. **ALLOWABLE EXPENSE** - shall mean all Prevailing Charges for treatment or service when at least a part of those charges is covered under at least one of the Plans then in force for the Covered Person for whom benefits are claimed.

4. **CLAIM DETERMINATION PERIOD** - shall mean the part of a calendar year during which a Covered Person would receive benefit payments under this Plan if this Article were not in force.

C. EFFECT ON BENEFITS - Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period shall be reduced if:

1. benefits are payable under any other Plan for the same Allowable Expenses; and

2. the rules listed in Section 10.04 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction shall be the amount needed to provide that the sum of payments under this plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this Article shall be reduced proportionately; any such reduced amount shall be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans shall include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable shall include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

D. ORDER OF BENEFIT DETERMINATION - Benefits payable from a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this Article are determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination shall be:

1. EMPLOYEE vs. DEPENDENT / PRIMARY vs. SECONDARY. The benefits of a Plan that cover the person for whom benefits are claimed as an Employee (other than as a Dependent) are determined before the benefits of a Plan that cover the person as a Dependent.

2. DEPENDENT CHILD - PARENTS NOT SEPARATED OR DIVORED (Birthday rule). Except as stated in Paragraph 3 below, when this Plan and another Plan cover the same child as a Dependent of different persons the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

If, however, another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. NATURAL DEPENDENT CHILD - SEPARATED OR DIVORCED PARENTS. If two or more Plans cover a Dependent child of divorced or separated parents or parents not living together, benefits for the child are determined in this order:

    a. first, the Plan of the natural parent with custody of the child;

    b. then, the Plan of the spouse (if any) of the parent with custody of the child;

    c. the Plan of the natural parent not having custody of the child;

    d. the Plan of the spouse (if any) of the non-custodial parent.

    If there is joint physical custody of the children, without the Court stating that one parent must be "primary," but the Court uses words like "maintain or carry insurance," then the Plan that has been in effect longer is the primary plan.

    If, however, the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or coverage, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. (Primary)

4. OTHER DEPENDENT CHILDREN. This Plan shall always pay secondary to any other group type coverage.

5. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

6. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person (for whom the claim is filed) for the longest period will pay first.

7. DEPENDENTS OF DECEASED ACTIVE EMPLOYEES. This Plan shall always pay secondary to any other group type coverage.

E. COORDINATE WITH MEDICARE

1. EMPLOYEES CONTINUING TO WORK AFTER AGE 65. If you continue to work for a contributing employer after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for her before Medicare pays unless it is legally permitted to pay second. If she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

2. RETIREES (AND THEIR SPOUSES) ELIGIBLE FOR MEDICARE. If you are an eligible retiree, and if you and/or your spouse are eligible for Medicare and have enrolled in both Medicare Part A and Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay after Medicare pays, based on amounts not paid by Medicare. The Plan will determine its benefits as the secondary payor based on the amount of the charge allowed by Medicare—it will not pay any amount in excess of Medicare's allowable charge.

   If you have not enrolled in Medicare Parts A and B, this Plan will calculate its benefits as if you had. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Parts, unless a different payment is required by law. You will have to pay the amount normally paid by Medicare.

   Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan.

3. MEDICARE-ELIGIBLE PERSONS UNDER 65. If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. This provision doesn't apply to retirees or their dependents.

4. ALL MEDICARE-ELIGIBLES AGE 65 OR OVER. Persons age 65 or older are also entitled to select Medicare as their coverage. To do so, they must decline all coverage under this Plan. Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

F. EXCHANGE OF INFORMATION - Any Covered Person who claims benefits under this Plan shall, upon request, provide all information the Trust believes is needed to coordinate benefits as described in this Article.

All information the Trust believes is needed to coordinate benefits shall be exchanged with other plans, companies, organizations, or persons.

G. FACILITY OF PAYMENT - The Trust may reimburse any other Plan if benefits were paid by that other Plan but should have been paid under this Plan in accordance with this Article.

In such event, the reimbursement amounts shall be considered benefits paid under this Plan and, to the extent of those payments, shall discharge the Trust from liability.

ARTICLE XVII. CLAIMS AND APPEAL PROCEDURE

The following procedures apply to the Eligibility Provisions and Indemnity Plan Benefits included in this booklet. They also apply to Dental, Vision & Life Insurance claims only after the Member has

exhausted the appeal procedures that are available through the respective carriers. For HMO, Dental, Vision, Life Insurance or AD&D Claims, please refer to the claims procedures in the Supplemental Summaries available in the Trust Fund Office. The Board of Trustees has established the claims and appeals procedures with the intent of comply with the regulations issued by the U.S. Department of Labor.

A. HOW TO FILE A CLAIM

Claims are paid in accordance with bills and forms supplied by hospitals and attending physicians. A claim shall be considered to have been filed as soon as it is received by the Trust Fund Office at its principal office, provided it is substantially complete, with all necessary documentation. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim. **All claims for benefits must be filed within 12 months from the date of treatment or service.** Failure to do so will result in non-payment. Have your Physician forward claims directly to the Plan Office. It is your responsibility to ensure that proofs of claims are timely filed with the Trust Fund Office.

Retiree members and their dependents that are eligible for Medicare should have the hospital and doctors submit claims to Medicare first. After Medicare has made a payment, a copy of the Medicare Explanation of Benefits Worksheet should then be submitted with a claim to the Trust Fund Office for processing.

B. CLAIMS AND APPEALS PROCEDURES

1. DEFINITIONS.

a) Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) for a service, supply or benefit under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(1) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);

(2) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(3) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not Medically Appropriate;

(4) a restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and

(5) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules

predetermined by the Plan).

b) Claim. The term "Claim" means a request for a benefit made by a Participant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for precertification or prior authorization of a benefit that does not require precertification or prior authorization by the Plan is not considered a Claim. However, requests for precertification or prior authorization of a benefit where the Plan does require precertification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.
Claims are categorized as Follows:

(1) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(2) Pre-Service Claim. The term "Pre-Service Claim" means 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.

(3) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

(4) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

(5) Disability Claims. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

c) Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative

processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

2. NOTICE OF CLAIM DENIAL

If a claim is wholly or partially denied, the claimant shall receive a written notice of denial as follows:

a) Contents of Notice: The notice of denial shall contain the following, written in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

b) Time of Notice: To assure that you are eligible for medical or hospital benefits, you should call or have your physician /hospital call the Trust Fund Office to pre-certify your eligibility for benefits. In the event that you do not obtain precertification and the Trust Fund Office determines that a claim is not covered for any reason, you will be notified of a claim denial:

c) Urgent Care: In the event the claim involves "urgent care," which is defined as any claim for medical care or treatment which in your physician's opinion is required immediately to avoid jeopardizing your life, health or ability to regain maximum function, you will be notified within twenty-four (24) hours of the submission of the claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours in the event coverage is denied.

d) Pre-Service Claims. A Pre-Service Claim is a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained as a condition of receiving maximum benefits allowed under the Plan. Under the terms of this Plan, claimants are not required to obtain precertification for any services.

e) Concurrent Claims. Any request by a Participant to extend an approved Urgent Claim will be acted upon by the Plan within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a Plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

f) Post-Service Claims. A Post-Service Claim must be submitted to the Trust Fund Office in writing, using an appropriate claim form, as soon as possible after expenses are incurred. A claim form may be obtained by contacting the Trust Fund Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim

within such time; however, in that case, the Claim must be submitted as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include any information requested by the Trust Fund Office.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Trust Fund Office.

Ordinarily, Participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Trust Fund Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Participant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the Participant, the Plan will issue a Request for Additional Information that specifies the information needed. The Participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is, suspended from the date of the Request for Additional Information until either 45 days or until the date the Participant responds to the request, whichever is earlier. The Plan then has 15 days to make a decision on the Claim and notify the Participant of the determination.

If the Plan determines that additional information is required from the Participant, and the Participant fails to provide any requested information within 45 days, the Plan will issue a Notice of Adverse Benefit Determination.

g) Disability Claim. A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the Participant of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Participant of the reason for the delay and the date by which the Plan expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the time the Plan notifies the Participant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the Participant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the

earlier of: (1) 45 days from the date of the notification; or (2) the date the Participant responds to the request. Once the Participant responds to the Plan's request for the information, the Participant will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

For an Adverse Benefit Determination on disability claims, the Content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based;
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
3. Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
6. Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
7. Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances require a further extension of time); and
8. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

h) Authorized Representatives. An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a Participant if the Participant has previously designated the individual to act on his/her behalf. An Appointment of Authorized Representative form, which may be obtained from the Trust Fund Office, must be used to designate an authorized representative. The Trust Fund Office may request additional information to verify that the designated person is authorized to act on the Participant's behalf.

A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete

the Appointment of Authorized Representative form.

i) Temporary Claims Filing Emergency Rules During Public Health Emergency. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency unless extended by federal mandate, any benefit claims filing requirements mentioned throughout this booklet, including One (1) year period to file suit), for claims **as of March 1, 2020**, has been temporarily tolled and counted from the end of the Outbreak Period. If applicable, for those claims received/processed earlier than March 1, 2020, any days that passed prior to the March 1, 2020 start of the Outbreak Period will not be disregarded in determining you or your authorized representative's claims filing deadline but the days that fall within the Outbreak Period will be temporarily tolled and counted from the end of the Outbreak Period.

3. APPEAL PROCEDURES.

a. **Appealing an Adverse Benefit Determination.** If a Claim is denied in whole or in part, or if the Participant disagrees with the decision made on a Claim, the Participant may appeal the decision. Appeals must be made in writing and must be submitted to the Trust Fund Office within 180 days after the Participant receives the notice of Adverse Benefit Determination.

(1) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made within 180 days after receipt of the Notice of Adverse Benefit Determination by either:

a. Calling the Trust Fund Office and asking to speak to the Utilization Review Representative. All oral requests must be followed by a faxed written request within 24 hours.

b. Faxing the request to the attention of the Utilization Review Representative.

Appeals of Urgent Claims may not be submitted via the US Postal service.

(2) Concurrent Claims. Appeals of Adverse Benefit 'Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(3) Post-Service and Disability Claims. The appeal of a Post-Service or Disability Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

a. the patient's name and address;
b. the Participant's name and address, if different;
c. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
d. the date of the Adverse Benefit Determination; and the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

b. The Appeal Process. The Participant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The Participant

will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his/her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on 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 that may be submitted by the Participant.

If the 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. Upon request, the Participant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

c. Time Frames for Sending Notices of Appeal Determinations.

(1) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund Office.

(2) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Trust Fund Office.

(3) Post-Service and Disability Claims. Ordinarily, decisions on appeals involving Post Service and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of Participant's request for review. However, if the request for review is received at the Trust Fund Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the Participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Participant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of Participant's Claim has been reached, the Participant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

If the decision on review is not furnished to the Participant within the time specified in this Subsection (C), Participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his/her Claim in accordance with Subsection e, below.

d. Content of Appeal Determination Notices. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

(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 the Participant is entitled to receive reasonable access to and

copies of all documents relevant to the Claim, upon request and free of charge;

(4) a statement of the Participant's 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, a statement that a copy is available upon request at no charge; and

(6) if the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

For Notice of denial of an appeal for Disability claims, the content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based;
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
3. Statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
6. Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and
7. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

e. <u>Trustee Interpretation, Authority and Right</u>. The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Parties to whom the Trustees have delegated the right of decision-making may also have the discretion to interpret the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to

make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. In addition, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependent at any time and in their sole discretion, since the Retiree Benefits are not "accrued" or "vested" benefits. Any such change made by the Trustees will be effective even though employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participant and beneficiaries.

f. <u>When a Lawsuit may be Started – One Year</u>.

(1) **<u>Statute of Limitations For Lawsuits</u>**. No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has **one** year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. In addition, a Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

This one-year limitation period covers any and all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

If, however, the Plan has failed to comply with the claims and appeals procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a disability claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency unless extended by federal mandate, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for filing a lawsuit. This means any right to file suit from the date you receive a denial of an appeal or adverse action as of March 1, 2020 will be temporarily tolled and counted from the end of the Outbreak Period.

No lawsuit may be started more than one year after the date on which medical or dental services were provided, or, if the Claim is for short term disability benefits, more than one year after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a Plan "Participant" or "beneficiary" within the meaning of those terms as defined in ERISA.

(2) Venue Restrictions. Effective January 1, 2021, any claim that you, your authorized representative, or your eligible dependent(s) may have relating to or arising under the Plan may only be brought in the U.S. District Court for the District of Nevada. No other court is a proper venue or forum for you, your authorized representative or eligible dependent's claim. The U.S. District Court for the District of Nevada will have personal jurisdiction over you and any other participant or beneficiary named in the action.

(3) Class Action Waiver. Effective January 1, 2021, the Plan and the Participants and Dependents agree that all Claims pursued against each other will be on an individual basis. To that end, the Participants and Dependents hereby waive their right to commence, to become a party to, or to remain a participant in, any group, representative, class, collective, or hybrid class/collective action in any court, arbitration proceeding, or any other forum, against the other.

g. Temporary Appeals Filing Emergency Rule During Public Health Emergency. For those claimants (or their authorized representatives) who received an adverse benefit determination/claims denial **as of March 1, 2020** the claimant (or authorized representative) has 180 days for health & welfare and disability-related claims, counted from the end of the Outbreak Period to file an appeal. If applicable, for those claimants who received an adverse benefit determination earlier than March 1, 2020 any days that passed prior to the March 1, 2020 start of the Outbreak Period will not be disregarded in determining you or your authorized representative's appeals filing deadline but the days that fall within the Outbreak Period will be temporarily tolled and counted from the end of the Outbreak Period.

ARTICLE XVIII. POTENTIAL LOSS OF BENEFITS

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

A. Exclusions/Co-Payments. The various plans and insurance policies contain exclusions that may preclude you from having coverage. You are also responsible for co-payments in most situations.

B. Ineligible. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

C. Not Timely. The claim wasn't filed within the Plan time limits.

D. Not Covered or Not Incurred. The expenses that were denied are not covered under the Plan or were not actually incurred.

E. **Full Benefit Provided**. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.

F. **Plan Change**. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.

G. **Recover Overpayment**. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf or on behalf of another member of the same family.

H. **Fail to File Complete Application** Benefits may not be payable until a completed application and other required forms and information is received by the Trust Fund Office.

I. **Incomplete Information/False Statements**. If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

J. **Inadequate or Improper Evidence**. The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Trust Fund Office any information or proof or coverage reasonably required to administer the Plan.

K. **Subrogation/Third Party Claims**. The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

L. **Coordination of Benefits**. If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

M. **Work-Related Injuries**. The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you have not filed a claim with workers compensation.

N. **Failure to Enroll in Medicare Parts A and B**. If you are eligible for and fail to enroll in Medicare parts A and B, the Plan will not pay many of your claims.

O. **Right to Recover Claims Paid or Offset of Future Claims**. The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

P. **Prohibited Employment in the Electrical Industry**. If you engage in certain kinds of work in the Electrical Industry, known as Prohibited Employment, you will no longer be entitled to Retiree Health and Welfare benefits.

Q. **Plan Termination**. If the Plan terminates, benefits may no longer be provided.

The preceding list is not an all-inclusive listing of the circumstances that may result in denial or loss or delayed payment of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements, that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Manager.

ARTICLE XIX. AMENDMENT/TERMINATION/MERGER OF PLAN

A. AMENDMENT OF PLAN

The Board of Trustees has the discretion to amend the Plan at any time. Moreover, if the Collective Bargaining Agreement is amended by the insertion or deletion of provisions relating to the Plan, the Board of Trustees will amend the Plan to effectuate the intent of the amendment to the Collective Bargaining Agreement, unless such amendment conflicts with applicable law or is actuarially unsound.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA. Except as is permitted or required by applicable law, no amendment may divest any accrued benefits which have previously been vested.

B. TERMINATION OF PLAN

It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan and to state the rights of the Participants in such an unlikely event.

The parties to the Collective Bargaining Agreements between IBEW Local 401 and the Employer associations may terminate the Plan in whole or in part. Although there is no intent to terminate the Plan, there is no guarantee that the Plan will last forever.

C. MERGER OR CONSOLIDATION

In the event of a merger or consolidation of the Plan with, or transfer in whole or in part, of the assets or liabilities of the Plan to any other Pension Plan, each Participant is entitled to a benefit immediately after the merger, consolidation or transfer which is at least equal to the benefit such Participant would be entitled to receive before such merger, consolidation or transfer.

ARTICLE XX. ADDITIONAL INFORMATION REQUIRED BY ERISA

A. NAME AND TYPE OF PLAN

The name of the Plan is the Electrical Workers Health and Welfare Plan for Northern Nevada. The Plan is tax-exempt under Section 501(c)(9) of the Internal Revenue Code.

B. PLAN ADMINISTRATOR

The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board is responsible for the operation and administration of the Plan, including ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Board has contracted with Benefit Plan Administrators Inc. to be the Fund Manager for the Plan. You may contact the Plan as follows:

Jim Mace, Fund Manager
Electrical Workers Health & Welfare Plan for Northern Nevada
445 Apple Street
P.O. Box 11337
Reno, NV 89510

C. PLAN SPONSOR

The Plan is sponsored by a joint labor-management Board of Trustees, the name and address of which is set forth in Section B above.

D. AGENT FOR THE SERVICE OF LEGAL PROCESS

The person designated as agent for service of legal process is:

Richard K. Grosboll and/or Lois H. Chang
Neyhart, Anderson, Flynn & Grosboll APC
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
(415) 677-9440

Service of legal process may also be made upon the Fund Manager, any Plan Trustee, or the Board of Trustees, at the addresses listed on page ii of this booklet.

E. PLAN YEAR

The Plan Year commences on January 1 and ends December 31.

F. EMPLOYER IDENTIFICATION NUMBER

The Internal Revenue Service Employer Identification Number (EIN) for this Plan is 94-2363944. The Plan Identification Number is 501.

G. FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with Collective Bargaining Agreements between the IBEW Local 401 and certain designated Employer associations (and some individual Employers), which require Employers to contribute to the Plan. The hourly contribution rate is specified in the applicable collective bargaining agreement. Copies of the collective bargaining agreement can be obtained from the IBEW Local 401 union office.

The Trust Fund Office will provide you upon written request with information on whether a particular Employer for whom you work is contributing to the Plan and if the Employer is a contributor, the Employer's address.

H. FUND MEDIUM

Assets of the Plan are held in Trust are held in custody of Amalgamated Bank. The Board of Trustees has retained ANDCO Investments as the Plan's Investment Consultants,. The Board of Trustees may select other Investment Consultants in the future. The Board of Trustees makes the investment decisions to the Plan Assets.

I. SOURCE OF CONTRIBUTIONS

The Plan is funded through employer contributions the amount of which is specified in the applicable Collection Bargaining Agreement or the amount specified by the Board of Trustees for non-bargaining unit employees. Also, self-payments by employees or dependents are permitted as outlined in this booklet. The amount of self-payments is established from time to time by the Board of Trustees.

J. STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan Participants are entitled to:

(1) RIGHT TO RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS

a. Examine without charge at the Trust Fund Office and at other specified locations such as worksites and the Union office, documents governing the Plan, including Collective Bargaining Agreements, insurance contracts (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Department of Labor (and which is also available at the Public Disclosure room of the Department of Labor's Employee Benefits Security Administration ("EBSA") office.

b. Obtain copies of Plan documents governing the operation of the Plan (ex. Updated Summary Plan Description, Collective Bargaining Agreements, Copies of the latest annual report, insurance contracts) upon written request to the Plan. Pursuant to ERISA, the Trust Fund Office may require that you pay a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with a copy of this SAR.

d. Continue health coverage for yourself, eligible spouse or dependent child(ren) 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 booklet for the rules governing COBRA continuation coverage rights.

(2) PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for operating the Plan. The people who operate your Plan, called "fiduciaries," 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 or entity, 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.

(3) <u>ENFORCING YOUR RIGHTS UNDER ERISA</u>

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to know why this was done, to obtain copies of applicable documents relating to the decision, and to have the Plan review and reconsider your claim, without charge and all with certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan such as certain Plan documents or the latest annual report (Form 5500) and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $112 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator or the Plan's delegate's control.

If you have a claim for benefits which is denied or ignored in whole or in part, and which is upheld on appeal (or ignored), you may also file a lawsuit. **Under the Plan, you are required to file a lawsuit within one year after your appeal has been denied or other action, omission or decision which adversely affected you or your dependent's benefits**. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or other assets, 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.

If you file a lawsuit, the court will decide who should pay court costs and legal fees to. If you are successful, the court may order the person(s) you have sued to pay your costs and fees to the prevailing party. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees (e.g., your claim was frivolous). **Again, no lawsuit may be filed more than one year after services were provided or benefits were partially or totally denied, or an otherwise adverse benefit determination was made against you.**

If you have any questions about your Plan, you should contact the Trust Fund Office.

If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Plan Administrator, you should contact Employee Benefits Security Administration (EBSA), U.S. Department of Labor at EBSA's toll free number at 866-444-3272 or electronically at www.askebsa.dol.gov. or write to the Department's national office at the following address:

Division of Technical Assistance and Inquires
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you. You may find answers to your questions and a list of EBSA offices at: **http://www.dol.gov/ebsa/welcome.html**.

ELECTRICAL WORKERS HEALTH AND WELFARE PLAN FOR NORTHERN NEVADA

ADOPTION RESOLUTION

RESOLVED, that effective January 1, 2021, the Trustees of the Electrical Workers Health and Welfare Plan for Northern Nevada adopt this Restated Summary Plan Description and Plan of benefits providing Comprehensive Medical, Vision and Dental Benefits.

The benefits provided by the Plan can be paid only to the extent that the Plan has available resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder, beyond the obligation of the contributing employer to make contributions as stipulated in the applicable collective bargaining agreement. Likewise, there shall be no liability imposed upon the Board of Trustees, individually or collectively, or upon the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

APPROVED:

Jacob Hess, Chairman

Date

Fran McDermott, Co-Chairman

Date

SPD 115