NORTHERN NEVADA ELECTRICAL WORKERS HEALTH & WELFARE and PENSION TRUST FUND

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April 14, 2023

TO: **Participants and Dependents**

FROM: **Board of Trustees of the Northern Nevada Electrical Workers Health & Welfare Plan**

RE: **Important Notice/Summary of Material Modifications ("SMM")**
Preparing for End of Public Health Emergency (COVID-19 Coverage/Outbreak Period Relief Coming to End)

Recently, President Biden and the Department of Health and Human Services announced that they intend to end the public national health emergency ("PHE") at the end of the day on **May 11, 2023**. In anticipation of the end of the PHE, we are providing you with this Important Notice regarding COVID-19 testing, vaccination and treatment and the end of the temporary emergency relief for certain COBRA election, special enrollment and claims and appeals (external review) deadlines, that may or may not impact you and your family after May 11, 2023.

I. END OF PUBLIC HEALTH EMERGENCY PERIOD (COVID-19 COVERAGE EXTENSION)

Please note the Northern Nevada Electrical Workers Health & Welfare Plan ("Plan") is a Grandfathered multiemployer group health plan. We are pleased to announce the Trustees have elected to continue coverage of COVID-19 vaccines, testing and treatment, at No Change to you and your eligible family members until the end of the calendar year December 31, 2023.

FOR PLAN ENROLLEES (Beginning May 12, 2023 through December 31, 2023)

- **COVID-19 vaccines (including boosters)** will be covered under preventive benefits at $0 cost-share and no prior authorization.
- **COVID-19 PCR testing** will be covered as a lab diagnostic benefit at $0 cost-share including rapid diagnostic and swab-and-send tests, at in-network locations. (If you go out-of-network an applicable cost-sharing may apply).
- **COVID-19 over-the-counter (OTC) antigen tests through Optum RX (Pharmacy Benefit Manager)** will continue to give up to 8 home antigen tests per month at $0 cost share if obtained at pharmacy or with a post-service reimbursement claim and up to $12 reimbursement for OTC tests obtained out-of-network.
- **COVID-19 anti-viral medications like Paxlovid (through ESI)** will continue to be covered at $0 cost-share until the government-funded supply runs out and members (and their eligible dependents) will continue to pay the applicable normal cost sharing for COVID-19 Treatments (through the medical plan) such as hospital stay or facility fees.
- **Telehealth/medicine and remote care services** for medically necessary services including covered behavioral/mental health and substance abuse care will continue to be covered. If this is further extended or terminated you will be notified.

II. END OF TEMPORARY OUTBREAK PERIOD RELIEF OF CERTAIN COBRA, SPECIAL ENROLLMENT AND CLAIMS & APPEALS DEADLINES

As a reminder, back in May 4, 2020, the Internal Revenue Service and Department of Labor jointly adopted an emergency regulation that temporarily extended certain COBRA election, COBRA payment, special enrollment, and claims and appeals deadlines during the COVID-19 "Outbreak Period." The Outbreak Period is defined as the period between March 1, 2020 and the date that is sixty (60) days following the announced end of the "National Emergency."

Group Health plans (such as the **Northern Nevada Electrical Workers Health & Welfare Plan**) (hereinafter referred to as "the Plan") were required to disregard the Outbreak Period when determining deadlines (in other words extend deadlines) for the following periods and dates:
(1) the 60-day election period for electing COBRA continuation coverage,
(2) date for making payment of COBRA premiums,
(3) date for providing COBRA election notice,
(4) date for notifying the Plan of a Qualifying Event that is a divorce, separation, loss of dependent status or a disability,
(5) date for filing a claims and/or appeal of an adverse benefit determination under the Plan's claims procedure including external review (if applicable); and
(6) 30-day period (or 60-day period if applicable) to request special enrollment in certain circumstances.

What that means is that any original deadlines for electing COBRA, making COBRA premium payments and notifying the Plan of a Qualifying Event for Special Enrollment would not begin to run until the earlier of one year from the date an individual first became eligible for an extended deadline or the end of the Outbreak Period. But, the disregarded period cannot exceed one (1) year. **Legislation was recently passed to end the COVID-19 "National emergency" as of April 10, 2023 that means the Outbreak Period will end 60 days after that which is June 9, 2023. As of June 9, 2023, the temporary extensions under the emergency relief for timeframes that began during the national emergency will no longer apply.** IMPORTANT: **Certain individuals may have been entitled to this relief on an individualized basis but the relief does not apply in every situation!!!**

The following examples recently released by the federal governments show how these rules work. Please note these are just examples and not specific to your situation.

Example 1 (Electing COBRA)

Facts: Individual A works for Employer X and participates in Employer X's group health plan. Individual A experiences a qualifying event for COBRA purposes and loses coverage on April 1, 2023. Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on May 1, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: The last day of Individual A's COBRA election period is 60 days after June 9, 2023 (the end of the Outbreak Period), which is August 8, 2023.

Example 2 (Electing COBRA)

Facts: Same facts as Example 1, except the qualifying event and loss of coverage occur on May 12, 2023, and Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on May 15, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: Because the qualifying event occurred on May 12, 2023, after the end of the COVID-19 National Emergency but during the Outbreak Period, the extensions under the emergency relief notices still apply. The last day of Individual A's COBRA election period is 60 days after June 9, 2023 (the end of the Outbreak Period), which is August 8, 2023

Example 3 (Electing COBRA)

Facts: Same facts as Example 1, except the qualifying event and loss of coverage occur on July 12, 2023, and Individual A is eligible to elect COBRA coverage under Employer X's plan and is provided a COBRA election notice on July 15, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: Because the qualifying event occurred on July 12, 2023, after the end of both the COVID-19 National Emergency and the Outbreak Period, the extensions under the emergency relief notices do not apply. The last day of Individual A's COBRA election period is 60 days after July 15, 2023, which is September 13, 2023.

Example 4 (Paying COBRA Premiums)
Facts: Individual B participates in Employer Y's group health plan. Individual B has a qualifying event and receives a COBRA election notice on October 1, 2022. Individual B elects COBRA continuation coverage on October 15, 2022, retroactive to October 1, 2022.

When must Individual B make the initial COBRA premium payment and subsequent monthly COBRA premium payments?

Conclusion: Individual B has until 45 days after June 9, 2023 (the end of the Outbreak Period), which is Julyt 24, 2023, to make the initial COBRA premium payment. The initial COBRA premium payment would include the monthly premium payments for October 2022 through June 2023. The premium payment for July 2023 must be paid by July30, 2023 (the last day of the 30-day grace period for the July 2023 premium payment). Subsequent monthly COBRA premium payments would be due the first of each month, subject to a 30-day grace period.

Example 5 (Special Enrollment Period)
Facts: Individual C works for Employer Z. Individual C is eligible for Employer Z's group health plan, but previously declined participation. On April 1, 2023, Individual C gave birth and would like to enroll herself and the child in Employer Z's plan. However, open enrollment does not begin until November 15, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as early as the date of the child's birth, April 1, 2023. Individual C may exercise her special enrollment rights for herself and her child until 30 days after June 9, 2023 (the end of the Outbreak Period), which is July 9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Example 6 (Special Enrollment Period)
Facts: Same facts as Example 5, except that Individual C gave birth on May 12, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as of the date of the child's birth, May 12, 2023. Because Individual C became eligible for special enrollment on May 12, 2023, after the end of the COVID-19 National Emergency but during the Outbreak Period, the extensions under the emergency relief notices still apply. Individual C may exercise her special enrollment rights for herself and her child until 30 days after June 9, 2023 (the end of the Outbreak Period), which is July9, 2023, as long as she pays the premiums for the period of coverage after the birth.

Example 7 (Special Enrollment Period)
Facts: Same facts as Example 5, except that Individual C gave birth on July 12, 2023.

When may Individual C exercise her special enrollment rights?

Conclusion: Individual C and her child qualify for special enrollment in Employer Z's plan as of the date of the child's birth, July 12, 2023. Because Individual C became eligible for special enrollment on July 12, 2023, after the end of both the COVID-19 National Emergency and the Outbreak Period, the extensions under the emergency relief notices do not apply. Individual C may exercise her special enrollment rights for herself and her child until 30 days after July 12, 2023, which is August 11, 2023, as long as she pays the premiums for the period of coverage after the birth.

Please contact the Administrator's office if you believe your situation met the special rules above. Otherwise, there is No Action necessary on your part.

IN ACCORDANCE WITH THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS SMM SUPPLEMENTS THE SUMMARY PLAN DESCRIPTION (WHICH IS ALSO THE PLAN DOCUMENT) AND IS COLLECTIVELY KNOWN AS THE "PLAN RULES", THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE PLAN'S RULES.

If you have any questions, please contact the Administrator's office (number located in letterhead above)

Respectfully submitted,
Administrative Office

Northern Nevada Electrical Workers Health & Welfare Plan
Mail Claims to: Post Office Box 11337, Reno, NV 89510
Street Address: 445 Apple Street, Suite 109, Reno, NV 89502
Telephone: (775) 826-7200

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory,

neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

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

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

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

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

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

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

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July 11, 2022

To: All Plan Participants and Dependents

Re: SUMMARY OF MATERIAL MODIFICATIONS/PLAN CHANGES

We understand that mailings can be overwhelming, so we are providing you with a brief summary in this introduction to help you better understand what is being sent to you. This Summary of Material Modifications ("SMM") describes important changes that have been made to the NORTHERN NEVADA ELECTRICAL WORKERS HEALTH AND WELFARE PLAN ("the Plan") as required by the Consolidated Appropriations Act of 2021 and the No Surprises Act, effective January 1, 2022. The No Surprises Act provides you with protections against surprise medical bills from out-of-network providers for certain claims only.

Please carefully review the changes to the Plan and keep it with your recent copy of the Plan's Summary Plan Description and Plan Document (which is known as the "Plan Rules"). No Further Action is Required of You. It is being provided for informative purposes.

Article VI. Definitions

Amendment to Definitions Section
(Effective Jan. 1, 2022 Pursuant to Federal Mandate)

The following definitions have been amended and/or added to the "**Definitions**" Section of the Plan Rules (both the Summary Plan Description and Plan Document).

15. 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.

Effective 1/1/2022, for **Non-Contract Provider Emergency services, non-emergency services provided by a Non-Contract Provider at a Contract facility** and **Air Ambulance Services**, the Allowable Charge or Allowable Expense or Covered Expense is the "Recognized Amount."

17. Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe 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.

Effective January 1, 2022, the emergency department of a hospital also includes an independent freestanding emergency department (meaning a health care facility that is geographically separate from a hospital under applicable state law and provides emergency services).

Effective January 1, 2022, urgent care centers and urgent care clinics are also included in the definition of emergency services provided the center is permitted to provide emergency services under State license laws.

52. **"Recognized Amount"** means (in order of priority) one of the following:

(i) If applicable, the amount determined by All-Payer Model Agreement under Section 1115A of the Social Security Act;

(ii) If applicable, the amount specified by State law (as applied to plan regulated by state law);

(iii) The lesser of the billed amount charged by the provider or facility or the Qualifying Payment Amount.

For air ambulance services furnished by Non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

53. **"Qualifying Payment Amount"** means the amount calculated using the method described in the No Surprise Act regulations under 29 CFR 716-6(c).

54. **"Ancilliary Services"** means with respect to a Preferred Provider facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
4. Items and services provided by a Non-Preferred provider if there is no preferred provider who can furnish such item or service at such facility.

55. **"Independent Free Standing Emergency Department"** means a health care facility that is geographically separate from a hospital under applicable state law and provides emergency services.

56. **"Serious and Complex condition"** means with respect to a participant or dependent, one of the following:

(i) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability;

(ii) in the case of a chronic illness or condition, a condition that is a life threatening, degenerative, potentially disabling or congenital; and requires specialized medical care over a prolonged period of time.

Article VIII. COVERED EXPENSES

Amendment to Emergency Services, Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility, & Air Ambulance Services.

(Effective Jan. 1, 2022 Pursuant to Federal Mandate)

There are three categories of services subject to new rules, as explained in detail below. You cannot be balanced billed for such services. You will also only have to pay the same cost-sharing amount as if you had used a Network Provider and any copayments for such services will count towards your annual out-of-pocket maximum. The three categories of services to which these protections against surprise medical bills apply are: **(1) Emergency Services provided by Out-of-Network Providers, (2) Non-Emergency Services provided by Out-of-Network Provider at an In-Network Facility**, and **(3) Air Ambulance Services Provided by an Out-of-Network Provider.**

18. Emergency and Trauma Treatment. This is no limit to the number of Hospital Emergency room visits per participant (for each eligible member, spouse, or dependent child). **Effective January 1,**

2022, emergency services (including medical screening, ancillary services pre-stabilization services, treatment to stabilize an individual and post-stabilization services) will be covered:
(i) without prior authorization regardless of whether received in-network or out-of-network;
(ii) without regard as to whether provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable, with respect to the services,
(iii) without conditions such as denials based on final diagnosis codes,
(iv) without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods or applicable cost-sharing requirements,
(v) without administrative requirements or limitations that are more restrictive than those applied to in-network emergency services and facilities,
(vi) Any cost-sharing for out-of-network emergency items and services will not be greater than the in-network cost sharing amount that would apply had the items and services been provided by a participating provider or participating emergency facility,
(vii) Any cost-sharing payments made by the participant or dependent will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

Contract Provider	**All Employees (Except Sound and Communication Workers):** 80% of the first $5,000 of Out of Pocket maximums 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 Out of Pocket maximums incurred during a calendar year and 100% thereafter for the remainder of the calendar year.
Non-Contract Provider	Benefits are payable the same as if received by Contract Provider.

5. Ambulance (Ground & Air).

(a) Ground Ambulance. Charges from a licensed professional ambulance service for the **ground** transportation of a Participant to or from a Hospital or Convalescent Hospital where medically necessary treatment is given is covered if the Fund determines that the location and nature of the Illness or Injury made the ground transportation cost effective or necessary to avoid the possibility of serious complications or loss of life.

(b) Air Ambulance. Effective January 1, 2022, licensed **air ambulance** (meaning medical transport by a rotary-wing air ambulance or fixed-wing air ambulance including inter-facility transports) includes both in-network and out-of-network air ambulance services are 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 (and where individuals conditions requires immediate air transportation that cannot be provided by ground ambulance). Effective January 1, 2022, any cost-sharing for out-of-network air ambulance services will not be greater than the in-network cost sharing amount and will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider. The new balance billing protections do not apply to ground ambulance bills.

48. Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility.

Effective January 1, 2022, medically necessary non-emergency items, services and visits that are otherwise covered by the Plan (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by a non-contract provider at in-network facilities (for which the participant or dependent has not knowingly and voluntarily provided consent

pursuant to the No Surprise act patient consent and notice requirements) are covered by the Plan as follows:

(i) cost-sharing will not be greater than the in-network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider,
(ii) Any cost-sharing payments made by the participant or dependent will count towards, if any, the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and
(ii) **Non-emergency Health Care Facilities** include hospitals (as defined in the Social Security Act Section 1861(e)), hospital outpatient department, critical access hospitals (as defined in the Social Security Act section 1861(mm)(1)) and ambulatory surgical centers (as defined in the Social Security Act Section 1833(i)(1)(A)).

Participants and dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for **certain non-emergency services** (ex. voluntarily choosing an out-of-network obstetrician for a scheduled delivery or choosing an out-of-network orthopedist for a knee replacement) except for non-emergency ancillary services mentioned below, and **post-stabilization services** (where attending emergency physician/treating provider determines individual can reasonably travel to in-network facility and provider/facility satisfies any other conditions laid out by federal and state agencies) **provided** the following patient consent and notice requirements under CAA Section 2799B-2(d) are also met:

(i) Notice and consent must be provided together and be physically separate from any other documents by Provider/Facility;
(ii) Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment.
(iii) Notice and consent must list provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region.
(iv) Copy of signed consent must be provided to patient (via in-person or through mail or email) method selected by patient.

However, providers/facilities cannot ask participants and dependents to give up protections not to be balance billed for:

(i) Emergency services;
(ii) Air ambulance services;
(iii) Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work); and
(iv) Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

IMPORTANT: You're never required to give up your protections from Balance Billing. You also aren't required to get care Out-of-Network. You can choose Provider or Facility in the Plan's Network.
EXAMPLE: *If a participant has a covered surgery at a Network Hospital, but the doctor who administers the anesthesia to the participant is Out-of-Network, this rule will protect the participant from receiving surprise medical bills from the Out-of-Network Anesthesiologist. The Participant will be responsible only for his/her in-network cost-sharing (ie., $0 copay for surgery) and cannot be Balance Billed.*

Article XV. GENERAL PROVISIONS

Amendment to cover Consolidated Appropriations Act ("CAA") provisions such as ID Cards, Ensuring Continuity of Care, Accuracy of Provider Directory Information, and Surprise Billing Protections including Independent Dispute Resolution Process
(Effective Jan. 1, 2022 Pursuant to Federal Mandate)

EE. CONSOLIDATED APPROPRATIONS ACT OF 2021 ("CAA")

Effective January 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA.

1. **Identification Cards (CAA Section 107).** The Plan or Insurer's Identification Cards (physical or electronic) issued to a participant or its eligible dependents will include: (a) the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums, (b) telephone number and website address to seek further consumer assistance.

2. **Ensuring Continuity of Care (CAA Section 113).** When a medical/mental health/substance abuse provider or contracted facility is removed from the Plan or Insurer's (as applicable) coverage, following termination of the provider/facility contract between the Plan/Insurer and the Provider/Facility, the Plan/Insurer will timely notify participants or their eligible dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that: (a) the Provider/Facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

3. **Accuracy of Provider Directory Information (CAA Section 116).**

   (a) ***Verification Process.*** Not less frequently than once every ninety (90) days the plan or Insurer (as applicable) will verify and update its provider directory information included on the Plan or Insurer's database. Providers are required to submit regular updates to the plan to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.

   (b) ***Response Protocol.*** The Plan will respond to a participant or dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a provider's network status. The Plan must also retain communication records for two (2) years.

   (c) ***Database.*** The Plan or Insurer (as applicable) will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

   (d) ***Cost-Sharing for Services provided Based on Reliance on Incorrect Provider Network Information.*** If participant or dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Plan about a provider's network status prior to the visit and the item or services would otherwise be covered under the plan if furnished by a participating provider/facility, the Plan cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's

in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. Surprise Billing Protections (CAA Sections 102 and 105).

(a) ***Balance Billing Prohibition.*** Participants and dependents are prohibited from being balance billed for (1) **out-of-network emergency services**, (2) **non-emergency services performed by an out-of-network provider received at in-network facility**, and (3) **out-of-network air ambulance services**. Providers are prohibited from holding patients liable for excess amounts not covered by the Plan.

(b) ***Cost-Sharing Limits.*** In addition, for the three above-mentioned surprise items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the in-network cost sharing amount and must count towards the Plan's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The participant or dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

(1) Amount determined by All-Payer Model Agreement, if applicable;

(2) Amount under specified state law (as applied to plans regulated by state law);

(3) The lesser of the billed charge or **Qualifying payment amount** (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For out-of-network air ambulance bills the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

(c) ***Determination of Out of Network Rates.*** By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:

(1) Amount determined by All-Payer Model agreement, if applicable (does not apply to this Plan),

(2) Amount under specified state law (as applied to plans regulated by state law and does not apply to this Plan);

(3) Amount agreed upon by Plan/Insurer and Provider/Facility; and

(4) Amount determined by Independent Dispute Resolution Entity.

5. Patient Protections Disclosure Requirements Against Balance Billing

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

6. Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprise Act Items and Services (CAA Section 103).

A federal Independent Dispute Resolution ("IDR") process (also known as an arbitration procedure) is required for disputes involving out-of-network rates between the Plan/Insurer and Out-of-Network provider/facility (**"disputing parties"**) as it relates only to: **(1) out-of-network emergency services, (2) non-emergency services provided by a non-network provider at an in-network facility and (3) out-of-network air ambulance services.** Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 days of receiving initial payment or denial) to settle an out-of-network payment rate for covered items and services under the No Surprise Act. However, the Trust Fund reserves the right at any time in its sole discretion to settle a claim by agreement with a Non-Contract Provider, provided that, if the settled Claim is covered by the No Surprise Act the settlement does not result in higher participant or dependent cost-sharing as permitted under the No Surprise Act. If any federal court case including, government guidance, regulations, and/or subsequent law invalidates any portion of the IDR process, as it relates to the No Surprise Act, then the invalidated portions will also not apply to this Plan.

In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Independent Dispute Resolution	Timeline
Initiate **30 business day** open negotiation period	**30 business days** starts on date of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	**4 business days** starts the business day after open negotiation period ends
Mutual Agreement on certified IDR entity selection	**3 business days** after IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by the parties	**6 business days** after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	**10 business days** after date of certified IDR entity selection
Payment determinations made *(certified IDR issue binding determination selecting one of the parties' offers as the payment amount)*	**30 business days** after the date of certified IDR entity selection
Payment submitted to the applicable party	**30 business days** after the payment determination

Both parties are responsible for an administrative fee and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process. The 2022 administrative fee and allowable IDR entity fee ranges is available at: Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov)

Batched Items and Services. Batching means multiple items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the federal IDR process. Batching is also allowed for claims submitted within a 30-day period that meet the following criteria:

- Services furnished by the same provider or facility
- Services provided to participants and dependents under the same plan
- Services for treatment of similar conditions.

The party that initiated the IDR process cannot initiate a new IDR process with the same party and for same services for 90 days. However, on the 90 day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.

Factors Considered by IDR Entity.
When making a payment determination, the certified IDR entities must begin with the presumption that the Qualifying Payment Amount is the appropriate out-of-network amount. If a party submits additional information that is allowed under the statute, then the certified IDR entity must consider the information if it is credible. For the IDR entity to deviate from the offer closest to the Qualifying Payment Amount, any information submitted must clearly demonstrate that the value of the item or services is materially different from the QPA.

Within 30 days, the IDR entity selects one of the offers submitted and must consider:
- Offers by both parties; and
- Qualifying payment amount for the same service in the same geographic region.

The IDR entity can also consider the following factors:
- Training, experience, quality, and outcomes measurements;
- Market shares of parties;
- Acuity of patients/complexity of cases;
- Teaching status, case mix, scope of services of facility; and
- Good faith efforts by parties to contract and contracting rate history from last four years.

The IDR entity cannot consider:
- Usual and customary rates;
- Billed charges; and
- Payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare

7. External Review Rights for Certain No Surprise Act Items and Services (CAA Section 110).

Grandfathered plans (such as this Plan) that are not otherwise subject to external review requirements are subject to external review requirements for coverage decisions that involve whether a plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act. As such, eligible participants and dependents have the right to request external review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprise Act claims and services mentioned in this section. This means that, generally, you may only seek external review after a final determination has been made on your appeal. **External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied):**

(1) Out-of-network emergency services,
(2) Non-emergency services provided by a non-network provider at an in-network facility and
(3) Out-of-network air ambulance services.

External review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the plan or insurer that involves medical judgment, including but not limited to, those based on the plan's or insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the plan or insurer is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and §§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for external review include:
(i) Whether a particular item or service constitutes treatment for emergency services.
(ii) Whether services provided by an out-of-network provider at in in-network facility is subject to the No Surprise Act.

(iii) *Whether an individual was in a condition to receive Patient protection notice under the No Surprise Act and able to waive the right to those protections.*

(iv) *Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.*

(v) *Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.*

The Plan will comply with an applicable external review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations.

There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Care Claims.

(1) External Review of Standard Claims

a. Your request for external review of a standard (not urgent) claim must be made, in writing, within four (4) months of the date that you receive notice of an Claim Appeal Benefit Determination. For convenience, these Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

b. Within five (5) business days of the Plan's receipt of your request for an external review of a standard claim, the Plan will complete a preliminary review of the request to determine whether:

(i) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(ii) The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan.

(iii) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(iv) You have provided all of the information and forms required to process an external review.

c. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

(i) If your request is complete and eligible for external review; or

(ii) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(iii) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

d. Review of Standard Claims by an Independent Review Organization (IRO). If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(i) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

(ii) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(iii) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.
In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

(v) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. [If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

(vi) The assigned IRO's decision notice will contain:

i. A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

ii. The date that the IRO received the request to conduct the external review and the date of the IRO decision;

iii. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

iv. A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

v. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

vi. A statement that judicial review may be available to you; and

vii. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

(2) External Review of Expedited Urgent Care Claims.

a. **You may request an expedited external review if**: 1) you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or 2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

b. **Preliminary Review for an Expedited Claim.** Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described under Standard claims above). The Plan will immediately notify you (e.g. telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

c. **Review of Expedited Claim by an Independent Review Organization (IRO)**. Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g. meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, (described above under Standard Claims). In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(i) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

(ii) If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

GRANDFATHERED PLAN STATUS REMINDER

As a reminder, the Board of Trustees believes that the Electrical Workers Health and Welfare Plan for Northern Nevada Plan is a "grandfathered health plan" under the Affordable Care Act ("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 Act was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Act 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 Act, such as the elimination of annual and lifetime limits on Plan benefits.

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

Please keep this important notice with your Rules and Regulations/Summary Plan Description (SPD) for reference to all Plan provisions. If you have any questions, you may call the Trust Fund Office at (775) 826-7200 or Toll Free at (877) 826-5053.

IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE PLAN AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION AND OTHER PLAN MATERIALS FOR EASY REFERENCE TO ALL PLAN PROVISIONS.

IF YOU WISH TO VERIFY ELIGIBILITY, OR IF YOU HAVE ANY QUESTIONS REGARDING THE CHANGES DESCRIBED IN THIS SMM, PLEASE CONTACT THE TRUST FUND OFFICE.

Sincerely,

Board of Trustees

Electrical Workers Health and Welfare Plan for Northern Nevada

Street Address: 445 Apple Street, Suite 109, Reno, NV 89502
Telephone: (775) 826-7200

February 3, 2022

TO: Participants & Dependents

Re: Summary of Material Modifications for Over-the-Counter (OTC) At-Home COVID Tests

Dear Participant:

In response to the recent federal mandate, requiring group health plans and insurers to provide coverage for and/or reimbursement of over-the-counter (OTC) COVID-19 Home tests (without a prescription or doctor's note), the Board of Trustees is pleased to provide you with the following summary of changes to the self-funded Plan (through Optum RX the Pharmacy Benefit Manager). Please review the important change to the Plan's benefits described below.

Northern Nevada Electrical Workers Health and Welfare Plan ("Plan") Participants including their dependents are now able to purchase over-the-counter (OTC) at-home COVID-19 tests, at little or no cost to you. Beginning January 15, 2022, the Plan will cover FDA-authorized including COVID-19 tests that received FDA authorization for emergency use, OTC At-home COVID-19 diagnostic tests purchased on or after January 15, 2022, without a doctor's prescription. By having the Plan pay for your test kits, you are agreeing that the kits are for personal use and will not be used for employment or distribution purposes.

PLAN AMENDMENT – Article VIII, Section D. Subsection 44.1.
(Coverage of At-Home COVID-19 Testing Kits Without Doctor's Note-*Effective for purchases on or after January 15, 2022*)

Coverage of Over-the-Counter ("OTC") COVID-19 Tests. Effective for purchases on or after January 15, 2022 and during the public health emergency period, the Plan's self-insured coverage through the Pharmacy Benefit Manager (currently Optum RX) will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes coronavirus disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider.

Pursuant to federal guidance, the Plan or Insurers are permitted to make the following limitations (if applicable) under the Safe Harbors provided under FAQ Part 51:

(a) **Cost Limits (Through Pharmacy Network or Direct Coverage).** The Plan (through its Pharmacy Benefit Manager) or Insurer is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to no less than the actual price of the test or $12 per test (whichever is lower) if the Plan (through its Pharmacy Benefit Manager) or Insurer provides direct coverage (meaning the participant does not pay an upfront cost and instead the Plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs. Please note the Plan currently has an arrangement with Optum-RX to provide coverage of these OTC COVID-19 testing kits. As such, if you purchase an

At-Home testing kit from an outside retailer (ex. Amazon), your reimbursement will be limited to the actual price of the test or $12 per test (whichever is less).

(b) **Quantity Test limit.** The Plan or Insurer is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Children) per 30-day period (or calendar month). The Plan or Insurer are permitted to set more generous limits although not mandated.

To address suspected fraud or abuse the Plan or Insurer are permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

Please further note medically necessary COVID-19 tests received with a doctor's order or individual clinical assessment will continue to be covered at 100% no cost-sharing to you and your eligible dependents and will not be subject to any quantity limits. This new program only applies to COVID-19 tests received without a doctor's note.

How To Get OTC COVID-19 Home Tests Through Optum-RX (Pharmacy Benefit Network)

1. **Optum Store Online Direct Coverage.** OTC COVID-19 tests kits are available to Participants at $0 out-of-pocket cost (meaning you pay no upfront costs) through the Optum Online store.
   - ➔ The number of covered OTC tests are limited to 8 tests per participant (or beneficiary) every calendar month. That means covered members can get up to 8 individual tests per month (e.g., a family of 4 would be eligible for 32 tests a month).
   - ➔ You can order at-home COVID-19 tests online with $0 copay through the **Optum Store.** Sign-in to ***Store.Optumrx.com*** and go to "**Get at-home COVID-19 tests with $0 copay."** Click the order now link Smartphone users will need to scroll down to find the link. You will receive free shipping on orders over $45. TO meet this threshold, members will qualify for free standard shipping if you buy at least 2 boxes of COVID-19 test kits (4 total tests).

2. **Out-of-Network Tests.** In the event your local pharmacy charges for the OTC test or you purchase an OTC test outside of the pharmacy network or at other stores or online retailers, you can be reimbursed if you submit a claim form for reimbursement.

   - ➔ OTC COVID-19 tests purchased at non-preferred pharmacies or retailers will be reimbursed up to the lesser of $12 or the actual price.
   - ➔ The number of covered OTC tests are limited to 8 tests per participant (or beneficiary) every calendar month. That means covered members can get up to 8 individual tests per month (e.g., a family of 4 would be eligible for 32 tests a month).
   - ➔ There are two ways to submit your claim for reimbursement:
     a. **Submit Your Claim Online.** Keep your purchase receipt(s) to submit your reimbursement. Your Plan will reimburse up to $12 per test. Click on the link to start your online request form at the following: ***https://covidtest.optumrx.com/covid-test-reimbursement.***

        OR

     b. **Mail in Your Claim Form.** You can also print a **form** and then mail it in. But, please note you will receive reimbursement more quickly if you submit an online claim form. The mail in form is available at the following link for print out: ***https://www.optumrx.com/content/dam/rxmember/landing-page/pdfs/covid-19-test-kit-reimbursement-form.pdf***

The following OTC COVID-19 test kits are FDA-authorized and set up to process at an OptumRx participating pharmacy. The list will be updated on a regular basis as new products receive EUA clearance.

- BinaxNow Antigen COVID-19 test
- Carestart COVID-19 Antigen Home Test
- On/Go COVID-19 Antigen Self-Test
- Ellume COVID-19 home test
- IHealth COVID-19 Antigen Rapid Test

- Inteliswab COVID-19 Rapid Test
- QuickVue At-home COVID-19 Test

IMPORTANT: Please do not submit or mail your OTC COVID-19 testing reimbursement claims to the Trust Fund Office. Instead, file the claim directly through Optum RX via the website above or mail it to OptumRx.

Have questions. Call OptumRx prescription customer service at 1-800-248-1062 or visit **optumrx.com/testinfo** for the latest updates and information.

Separate Federal-Government Provided COVID-19 Tests (Shipped to Your Home)

Also, every home in the U.S. is eligible to order 4 free at-home COVID-19 tests through the Federal Government. Orders will usually ship in 7-12 days. Visit https://www.covidtests.gov/ to order your free tests. The kits provided by the government are at no cost to the Plan.

IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE PLAN AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION.

Sincerely,

Electrical Workers Health and Welfare Plan for Northern Nevada,

Board of Trustees

ELECTRICAL WORKERS HEALTH AND WELFARE PLAN FOR NORTHERN NEVADA

*445 Apple Street * P.O. Box 11337 * Reno, Nevada 89510 * (775) 826-7200*

December 2, 2021

TO: PARTICIPANTS & DEPENDENTS

RE: SUMMARY OF MATERIAL MODIFICATIONS ("SMM") for the ELECTRICAL WORKERS HEALTH AND WELFARE PLAN FOR NORTHERN NEVADA

In response to government regulations released regarding COVID-19 vaccinations and the FDA approval of certain COVID-19 vaccinations, this Participant Notice will advise you of recent temporary changes that have been made to the Summary Plan Description ("SPD") and Rules and Regulations of the Electrical Workers Health & Welfare Plan for Northern Nevada ("Plan") during the period of the public health emergency period. **This information is VERY IMPORTANT to you and your dependents. Please take the time to read it carefully.** Please further note under a priority four-tier system developed by the State of Nevada based on federal guidance, the State of Nevada has began administering the first doses only available to health care workers and to residents and staff in long-term facilities. In anticipation of these vaccinations, whenever it becomes available to you and your family based on State guidance, the Plan has amended its rules to prepare for the imminent administration of these vaccinations.

COVID-19 VACCINATION AND IMMUNIZATION BOOSTER COVERAGE (DURING PUBLIC HEALTH EMERGENCY PERIOD) ¥EFFECTIVE JANUARY 1, 2021

Added new Items 44.3 to Subsection D. of Article VIII. (Medical Benefits) to the Plan Document and SPD

Dear participants and family members:

The COVID-19 Booster Shot is now available to any Nevada adult who wants one. The booster shot is recommended six months after receiving the second Pfizer or Moderna vaccination shot. Those who received a Johnson & Johnson Janssen vaccine are recommended to get a booster shot two months or more after the first shot. Previously, boosters were only recommended for people at high risk due to job, age or other risk factors. Please consult with your doctor if you have any question or concerns. If you would like to receive a booster shot you can also visit ***//nvcovidfighter.org/covid-19-vaccine-locator*** *to find the closest vaccination site available to you and your family members. Please further note the booster shot is available to you and your family members at no cost. Meaning you should not be charged copayment, coinsurance or other form of cost-sharing including the cost for administering the vaccine for getting the booster shot. If the pharmacy or provider charges you for the booster shot it is not allowed and please contact the Trust Fund office if that happens. Stay safe,*

GRANDFATHERED HEALTH PLAN REMINDER

As a reminder, the Board of Trustees believes that the Electrical Workers Health and Welfare Plan for Northern Nevada Plan is a "grandfathered health plan" under the Affordable Care Act ("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 Act was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the Act 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 Act, such as the elimination of annual and lifetime limits on Plan benefits.

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

Please keep this important notice with your Rules and Regulations/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions, you may call the Administrative Office at (775) 826-7200 or Toll Free at (877) 826-5053.

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Sincerely,
Board of Trustees