NORTHERN NEVADA OPERATING ENGINEERS HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION (SPD) FOR THE DIRECT PAYMENT PLAN FOR:

Active Employees and Their Eligible Dependents Describing the Self-Funded Medical, Prescription Drug, Dental Care, Vision Care and Weekly Disability Benefits plus highlights of the insured Life, AD&D and Burial Benefits

Effective December 1, 2023

NORTHERN NEVADA OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND

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Introduction

What This Document Tells You

To All Eligible Employees:

We are pleased to provide you with this booklet describing your health care and insurance benefits under the Northern Nevada Operating Engineers Health and Welfare Trust Fund as of December 1, 2023. This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. This document replaces all other summary plan descriptions and applicable amendments to those documents previously provided to Plan participants.

This booklet covers the benefits of the Direct Payment Plan—benefits for which the Fund pays the claims for you and your eligible Dependents. The benefits included in the Direct Payment Plan are medical, prescription drug, dental, vision care and weekly disability benefits.

This booklet also covers benefits for which the Fund contracts with insurance companies—life insurance for you and your Dependents as well as accidental death and dismemberment insurance and burial expense benefits for you.

Summary Plan Description

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

About Your Benefits

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

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

Questions?

We encourage you to read this booklet carefully and keep it handy for future reference. Please share the booklet with your family.

If you have questions about your benefits, contact the Administrative Office at the address or telephone number on page 6. As a courtesy to you, the Administrative Office may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. You should understand, however, that only the Board of Trustees is authorized to interpret the benefits described in this booklet and that this authority cannot be delegated to Administrative Office staff. In addition, no employer or union, or any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees or act as an agent of the Board of Trustees.

Sincerely,

BOARD OF TRUSTEES

GRANDFATHERED HEALTH PLAN UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (THE AFFORDABLE CARE ACT)

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan administrator at (775) 826-7200

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or http://www.dol.gov/ebsa/healthreform/. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTENTS

Chapter 1: Overview

In this chapter you'll find:
- Quick Reference Chart
- Important notices
- Information on filing claims

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart:

CONTACTS REFERENCE CHART	
Information Needed	**Whom to Contact**
Administrative Office • Claim Forms • Medical (including treatment for Mental Health), Dental and Vision Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) **Precertification for Medical Necessity** • Precertification of inpatient hospitalizations and certain medical services • Case Management • Appeals of decisions **COBRA Administrator** • Information About COBRA • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification **PPO Network for Medical, Dental (including Orthodontic services) and Vision Care** • Medical Network Provider Directory • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price) **Weekly Disability Coverage** • Weekly Disability Claims and Appeals	**Benefit Plan Administrators, Inc.** 445 Apple Street, Suite 109 Reno, NV 89502 or P.O. Box 11337 Reno, NV 89510-1337 Phone: (775) 826-7200 Toll Free (877) 826-5053 Fax: (775) 826-7289 For a **provider directory (at no cost) or to find a Medical, Dental or Orthodontic PPO provider**, call the Administrative Office or go to www.oe3health.org. The www.oe3health.org website also includes other valuable information about your health plan including, but not limited to, enrollment forms, your HIPAA Privacy notice, your Summary of Benefits and Coverage (SBC) and a Preferred Provider Directory.
Union Office	**Operating Engineers Local 3** (775) 857-4440 (800) 922-6100

CONTACTS REFERENCE CHART	
Information Needed	**Whom to Contact**
Prescription Drug Program administered by the Pharmacy Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information	**OptumRx** (855) 672-3644 or www.optumrx.com TDD assistance: (855) 672-3644 (TTY 711) Mail order: • For physicians to call in prescriptions: (800) 797-7658 • For participants: (855) 672-3644
Life Insurance and Accidental Death and Dismemberment and Burial Benefit • Contact the Administrative Office to designate and/or change your beneficiary	**Life Insurance Carrier** Your beneficiary should notify the Administrative Office (or your Local Union Office) as soon as possible after your death. The Administrative Office will then send your beneficiary the forms necessary for filing proof of the loss. Your beneficiary should complete the claim form and attach a certified copy of the death certificate. An autopsy report may be required. The claim form should be mailed to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**The Privacy Officer** Phone: (775) 826-7200 Northern Nevada Operating Engineers Health and Welfare Trust Fund 445 Apple Street, Suite 109 Reno, NV 89502

Unfamiliar Term?

If you see a word whose meaning you're unsure of, check the glossary at the end of this SPD. It contains definitions of the many of words used in the SPD. Capitalized terms also have special meanings that you will find in the glossary.

Privacy of Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's Notice of Privacy Practices, distributed to all Plan participants, explains what information is considered "Protected Health Information (PHI)." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

If you have misplaced your copy of the Plan's privacy notice, please contact the Administrative Office to request a replacement.

The Rules and Regulations included in this booklet also provide information on the use and disclosure of PHI.

No Vested Rights

No individual shall have accrued or vested rights to benefits -under this Plan. Vested rights refers to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed.

Foreign Language Assistance:

*Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Administracion en (775) 826-7200.

Filing Claims

Information on how to file claims is included at the end of each of the chapters describing the individual benefits. For information on what to do if you disagree with the decision made in regard to your claim, see the “Claims Review Procedures” in Chapter 12, “Other Important Plan Information.”

Chapter 2: Participating in the Benefit Plan

In this chapter you'll find:

- Eligibility
- Enrollment
- When coverage starts
- Maintaining your eligibility
- Coverage during family/medical and military leaves
- Termination of eligibility
- After eligibility ends

Employee Eligibility

These types of Employees may become eligible for the benefits described in this booklet:

- **Employees of contributing employers**—You may participate in the benefit plan if you are covered by a collective bargaining agreement or subscription agreement negotiated by Operating Engineers Local Union No. 3 of the International Union of Operating Engineers that requires your employer to make contributions to the Health and Welfare Trust Fund on your behalf. Participation is also allowed for non-collectively bargained Employees of contributing employers when the employers enroll such Employees and make flat rate contributions for them each month.

- **Owner-Operators**—If you are an Owner-Operator (not eligible as a result of employment with a contributing employer), you may elect to participate in the Plan by making the required monthly flat rate contribution to the Trust Fund on your own behalf. To be eligible, you must be signatory to an approved Owner-Operator Agreement requiring such contributions and be a dues-paying member or pay a service fee to Operating Engineers Local No. 3.

NOTE: The Employee burial expense benefit may be provided for Employees not otherwise eligible through contracts issued to the groups participating in the Operating Engineers Burial Expense Program.

Establishing and Maintaining Your Eligibility

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

If You Have Coverage Elsewhere

If you or your Dependents have health care coverage elsewhere, you should be aware that benefits described in this booklet will be coordinated with the other coverage. You cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in Chapter 12 for more information.

Enrollment

Enrollment Forms

You must complete an enrollment form to:

- Designate your Dependents for coverage (and provide the Fund with a copy of each of your Dependent's Social cards); and
- Designate your beneficiary or beneficiaries for your life insurance, accidental death and dismemberment insurance, and burial expense benefits.

When submitting an enrollment card for a Dependent, the following **must** be provided:

- **Marriage:** A certified marriage certificate (if the marriage certificate is in a foreign language, it must be translated to English) and a social security card
- **Birth:** An official birth certificate from the state or country for each child that is enrolled showing the child is the biological child of the Employee (if the birth certificate is in a foreign language, it must be translated to English) and a social security card;
- **Stepchild:** the certified birth certificate, social security card, a copy of the divorce decree and marriage certificate;
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgement, decree or court order from a court of competent jurisdiction plus the child's birth certificate and social security card.
- **Adopted Child (or placement for adoption):** court order paper signed by the judge showing that the employee has adopted or intends to adopt the child, birth certificate and social security care.
- **Disabled Dependent Child:** current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as defined in this document) and that disability existed before the end of the month in which the child turned age 26 and is incapable of self-sustaining maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including a social security card and proof that the child is claimed as a dependent for federal tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** valid QMCSO document signed by a judge or a National Medical Support Notice.

In addition to the information above, "other insurance information" for each Dependent must be updated annually.

It is important that the Administrative Office have a completed enrollment card for you—your claims cannot be processed unless you have such a form on file.

If you need an additional enrollment form, you may obtain one from your Local Union Office or the Administrative Office. See the Quick Reference Chart in the Introduction Chapter of this booklet or from the www.oe3health.org.

Changes

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

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

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

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

DEPENDENT (INCLUDING SPOUSE) SOCIAL SECURITY NUMBERS NEEDED

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

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

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or http://www.cms.gov) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Medicare

If you are still an active Employee when you reach age 65, you may enroll in Medicare. This Plan will continue to provide primary coverage for you and Medicare will be secondary. You may elect Medicare as your primary coverage. If you elect Medicare as primary, this Plan will NOT provide secondary coverage. Medicare will provide primary coverage and the Plan will provide secondary coverage. If your Spouse reaches age 65 while you are still an active Employee, he or she may enroll in Medicare independently.

Collectively Bargained Employees

Your Hour Bank

The hours you work for contributing employers accumulate in an hour bank. Hours are then deducted each month to pay for your benefits. Each month, 110 hours will be deducted, beginning with your first month of eligibility. To maintain your eligibility, you must work at least 110 hours per month for contributing employers (or have excess hours in your hour bank, as explained below).

Banking Excess Hours

Whenever you work more than 110 hours during a month (or have more than 110 hours credited to you under these eligibility rules), the excess hours will be accumulated to provide subsequent eligibility. You can accumulate up to nine months of hour bank eligibility (990 excess hours). You will be allowed to keep and use the amount in your hour bank as of April 1, 2013. When your hour bank balance falls to or below nine months of eligibility, you will no longer be allowed to accumulate an hour bank in excess of nine months.

NOTE: Excess hours cannot extend coverage for periods in which you are working in non-qualifying employment—that is, working for a non-contributing employer of the type covered by the collective bargaining agreement. Also, if you perform work covered by the Operating Engineers collective bargaining agreement for an employer that is not a contributing employer, or you knowingly permit a contributing employer to contribute to the Fund for less than all of the hours you have worked, you will not be entitled to the benefit of this excess-hours provision, and all remaining hours in your hour bank will immediately be canceled.

If Your Employer Contributes at Less Than the Standard Rate

If your employer contributes at an hourly rate less than the standard industry contribution rate, you will be credited with hours actually worked up to a maximum of 330 to establish initial eligibility. All hours in excess of the initial 330 will be pro-rated - factored based on the ratio of your employer's contribution rate to the standard industry rate to determine your continuing eligibility.

The number of hours credited to the Employee's eligibility is determined by a base rate that uses 130 hours and adjusts with each change of the master rate and custom rate.

For example: *If you work 110 hours with a contribution rate of $1.50 and the standard contribution rate is $3.00, your pro-rated hours for continuing eligibility will be:*

$$\frac{\$1.50}{\$3.00} \text{ [or 0.5]} \times 110 \text{ hours}$$

or 55 hours. These 55 hours would then be added to your hour bank.

When Coverage Starts

You will become covered on the first day of the calendar month following a period of not more than three consecutive calendar months during which you worked at least 330 hours. On the first day of the month of your eligibility, 110 hours will be deducted from your hour bank.

If you have eligible Dependents, each Dependent will be covered for benefits when your eligibility is effective or when the individual becomes an eligible Dependent, whichever is later.

When Coverage Ends (for Collectively Bargained Employees)

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

- The date you enter the Armed Forces (the military) on full-time active duty;
- The date of your death;
- Midnight the last day of the month that your hour bank is exhausted;
- The last day of the month prior to which you become eligible for coverage as a retired Employee (but see "Retirees Under the Hour Bank System"); OR
- The date the Plan is discontinued or terminates.

Your Hour Bank will immediately be cancelled if:

- You perform work of the type covered by the Operating Engineers Collective Bargaining Agreement for an employer who is not a Contributing Employer, or
- You knowingly permit a Contributing Employer to contribute to the Fund on your behalf for less than all of the hours worked.

Re-Establishing Eligibility (for Collectively Bargained Employees)

If you lose your eligibility (your coverage terminates) because your hour bank is exhausted, you will again become eligible on the first day of the calendar month after your hour bank shows at least 110 hours, if this occurs within the 12 months immediately following the termination of coverage. If you are not reinstated within the 12-calendar-month period, any hours in your hour bank will be canceled and you must again meet the initial eligibility requirements (i.e., satisfy the 330-hour qualifying period applicable to new Employees).

For example... *Let's say you were last eligible for benefits in November 2013 and you next work 110 hours in October 2014. You would be eligible for benefits in November 2014. However, if you were last eligible in November 2013 but did not work 110 hours again until November 2014, you would need to re-establish eligibility by working 330 hours in three consecutive months or less.*

When You Work in More than One Area

Reciprocity

Reciprocity provides eligibility for Employees who would otherwise be ineligible for benefits because their work hours are divided between different health and welfare funds. Reciprocity operates only if the Operating Engineers Local Union No. 3 Reciprocity Agreement has been adopted by each of the funds in whose jurisdiction you work.

If you have worked in more than one area of Local 3, please notify the Administrative Office or the Local Union Office so that proper determination is made as to which Plan covers you.

If you have any questions on the operation of the Reciprocal Agreements, or require a complete listing of Reciprocal Agreements, please contact either the Administrative Office or the fund office (or your local union) of the other plan under whose jurisdiction you are working.

Freezing Your Hour Bank When You Become Eligible Under Another Local 3 Operating Engineers Plan

You may freeze your hour bank under this Fund if you earn eligibility under any other Local 3 Operating Engineers Health and Welfare Trust Fund. You will not be eligible under this Fund while your hour bank is frozen.

When the other coverage terminates, you may use the hours in your frozen hour bank. Eligibility under this Fund will begin on the first day of the month following termination of coverage under the other Operating Engineers Local 3 plan. The reinstatement provisions described in this chapter do not apply.

If your eligibility in the other plan does not terminate within 60 months, the hours in your frozen hour bank will be cancelled.

If You Change to a Flat Rate Job

If you accumulate an hour bank and then change to a job status where flat rate contributions are made to the Trust Fund for you, you will run out hour bank.

Monthly Flat Rate And Non-Collectively Bargained Employees

Monthly Rates

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

Classes of Employees

Non-Collectively Bargained Employees

A Contributing Employer may contribute on behalf of full-time non-collectively bargained Employees. The contribution rate is a monthly flat rate, which is determined by the Board of Trustees. The Contributing Employer must make a written election to enroll the full-time non-collectively bargained Employees.

Owner-Operators

An Owner-Operator is a person who is not employed by a Contributing Employer, but who is signatory to an approved Owner-Operator Agreement with the Operating Engineers Local Union 3 requiring flat-rate contributions to the Fund and who is a dues-paying member or service fees payer of the Union. If you are an Owner-Operator, you will pay the flat rate contributions yourself.

When Coverage Starts (for Monthly Flat Rate and Non-Collectively Bargained Employees)

A full-time non-bargained Employee will become eligible for Fund benefits on the first day of the month following the Fund's receipt of the Employer's written election, if the contributions are received. If the collective bargaining agreement requires contributions for both bargained and non-bargained Employees, coverage begins on the first day of the calendar month that follows receipt of the required contribution for that month. There will be a skip month between hours worked and eligibility.

An Owner-Operator will become eligible on the first day of the calendar month which follows receipt of his required contribution for that month.

Maintaining Eligibility

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

Termination of Eligibility (for Employees for Monthly Flat Rate And Non-Collectively Bargained Employees)

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

- The date you enter the Armed Forces (the military) on full-time active duty;
- The date of your death;
- The last day of the month for which the required monthly contribution is made on your behalf ;
- The last day of the month prior to the month you become eligible for coverage as a retired Employee; or
- The date the Plan is discontinued or terminates.

Re-Establishing Eligibility

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

Eligibility Provisions that Apply to Hour Bank, Monthly Flat Rate And Non-Collectively Bargained Employees

When The Plan Can End Your Coverage For Cause

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

Special Enrollment

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

Coverage During an FMLA Leave of Absence

The Fund assists Contributing Employers in complying with the Family and Medical Leave Act (FMLA) by extending benefits during a qualified leave of absence, up to twelve weeks in a year (in some cases, up to 26 weeks). During your qualified FMLA leave, you and your eligible Dependents continue to be covered under this Plan provided you were eligible when the leave began. Your employer determines whether your leave is qualified. Your employer must also report the hours (or months for non-collectively bargained Employees) and remit the applicable contributions for your coverage to be continued during your leave.

Coverage During Service in the Uniformed Services

If you are an active Employee whose employment is interrupted because of a furlough or leave of absence for military service in the Uniformed Services of the United States, Federal law provides certain rights to continued coverage under this Plan. You may choose to freeze your eligibility status or continue coverage for up to 24 months from the date service commences.

Duty to Notify the Fund: You have a duty to notify the Fund in writing that you have been called to active duty in the uniformed services as soon as possible but no later than 60 days after the date on which you will lose coverage due to the call to active duty, unless it is impossible or unreasonable to give such notice.

Fund Offers Continuation Coverage: Once the Fund Office receives notice that you have been called to active duty, you will be offered the right to elect USERRA coverage for yourself and any eligible Dependents covered under the Plan on the day the leave started. Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms.

The term "Uniformed Services" means the Armed Services (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 or emergency.

Freezing of Your Eligibility

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

If upon completion of service you notify your employer that you intend to return to employment as specified in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your eligibility will be reinstated. Eligibility will pick up as it was the day before you entered into Uniformed Services, without exclusion or waiting period, except for disabilities that the Department of Veterans Affairs has determined to be service connected.

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

Continuation of Coverage

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

- If your absence is due to a uniformed services leave of **31 days or less**, coverage will be continued at no cost to you. You will be credited with the hours necessary to keep coverage in effect as if you were working in covered employment with a contributing employer during the period of service.
- If your absence is due to a uniformed services leave of **31 days or more**, you or your Dependents may elect to continue coverage by paying premiums under the provisions of USERRA. See also the opportunity to elect COBRA instead of USERRA in the section above.

If you do not elect to continue coverage, eligibility status will be frozen as of the date of entry into Uniformed Services. Eligibility for coverage for any eligible Dependents will terminate at the end of the month in which you entered service in the Uniformed Services.

Service-Connected Illnesses and Injuries

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

Retirees Under the Hour Bank System

You may continue your health coverage by self-payment as described in “COBRA Continuation of Health Care Coverage” in Chapter 12.

If you are a collectively bargained Employee and you have at least one month of accumulated hour bank eligibility when you retire, your hour bank will be extended by three months. You will continue your coverage under this Plan as long as you have an hour bank balance large enough to provide such coverage.

Your eligibility for active coverage will end on the last day of the month upon exhaustion of coverage provided by your hour bank. Retiree coverage under the Pensioned Operating Engineers Health and Welfare Fund does not begin until active coverage terminates.

Dependent Eligibility

Eligible Dependents can be covered for health care benefits (medical, prescription drug, dental, vision care) and Dependent life insurance. Eligible Dependents include:

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

✓ Natural children; or

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

✓ Stepchildren or foster children;

✓ Children who are required to be covered by the Eligible Employee by a Qualified Medical Child Support Order (QMCSO).

Also covered are children over age 26 who are prevented from earning a living because of a mental or physical disability (providing the disabled children were so disabled and eligible as Dependents at the time they reached such limiting age), and are solely dependent upon the Employee for support. Evidence of the child's dependence and incapacity must be filed with the Board within 31 days after attaining age 26, and periodically thereafter.

When submitting an enrollment card for a Dependent, the following must be provided:

- **Marriage:** A certified marriage certificate (if the marriage certificate is in a foreign language, it must be translated to English) and a social security card
- **Birth:** An official birth certificate from the state or country for each child that is enrolled showing the child is the biological child of the Employee (if the birth certificate is in a foreign language, it must be translated to English) and a social security card;
- **Stepchild:** the certified birth certificate, social security card, a copy of the divorce decree and marriage certificate;
- **Foster Child:** court order documents signed by a judge verifying legal custody of the foster child (e.g. placement papers from a qualified state placement agency), or proof of judgement, decree or court order from a court of competent jurisdiction plus the child's birth certificate and social security card.
- **Adopted Child (or placement for adoption):** court order paper signed by the judge showing that the employee has adopted or intends to adopt the child, birth certificate and social security care.
- **Disabled Dependent Child:** current written statement from the child's Physician indicating the child's diagnoses that are the basis for the Physician's assessment that the child is currently mentally or physically disabled (as defined in this document) and that disability existed before the end of the month in which the child turned age 26 and is incapable of self-sustaining maintenance. The Plan may require that you show proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child including a social security card and proof that the child is claimed as a dependent for federal tax purposes.
- **Qualified Medical Child Support Order (QMCSO):** valid QMCSO document signed by a judge or a National Medical Support Notice.

In addition to the information above, "other insurance information" for each Dependent must be updated annually.

Termination of Eligibility for Dependents

A Dependent's eligibility will terminate when your coverage terminates or when the individual ceases to be an eligible Dependent.

Extensions During Total Disability

Extended Medical Benefits for Total Disability

If you or a Dependent is totally disabled (as certified by a physician) on the date eligibility terminates, the disabled individual will remain eligible for medical benefits **for the disability only** for up to 12 months. This extended coverage will end when the earliest of the following occurs:

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

This extension applies only to the disabled person and not to other family members. It covers charges only for that disability. It is available at the time of termination of eligibility but not after COBRA Continuation Coverage has been exhausted. To continue benefits for family members other than the individual who is disabled, COBRA coverage can be elected when active coverage is terminated.

Extended Life Insurance Coverage

Extended Coverage for You If You Become Disabled

Your Employee life insurance will stay in effect beyond the end of your eligibility as an active Employee if you become totally disabled and unable to work while you are insured under the Plan and before you have reached age 60. For purposes of this extended benefit, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience. See Chapter 8, "Employee Life Insurance," for more information.

Extended Coverage for Your Dependents If You Die

Life insurance for your insured Dependents will continue for six months from the date general health coverage terminates if such termination is due to your death.

After Eligibility Terminates

Handling of Your Health Care Coverage

Federal law has special provisions regarding health care coverage when Employees or Dependents lose eligibility for benefits coverage.

COBRA

Legislation known as COBRA gives you and/or your Dependents the option of temporarily continuing coverage at your own expense under certain circumstances when coverage would otherwise end. See "COBRA Continuation of Health Care Coverage" in Chapter 12 for more information.

Conversion of Life Insurance

Employee and Dependent life insurance may be converted to individual policies when coverage ends. See the chapters on those benefits for more information.

Separate Plan for Pensioners

When your coverage terminates because of your retirement, you may be eligible for coverage under the Pensioned Operating Engineers Health and Welfare Trust Fund, which is described in another booklet. Specific conditions for eligibility apply for retirees, and the Pensioned Operating Engineers Health and Welfare Plan has different benefits than the Plan covering active Employees.

If you are anticipating retirement, you should request a copy of the Pensioner's Booklet from the Administrative Office or District Office of the Union. You will be notified at the appropriate time upon retirement as to how to obtain a copy, if you have not already done so.

Other Option When Coverage Under This Plan Ends

When coverage under this Plan terminates you may want to look into your options to buy an individual insurance policy for health care coverage from the Health Insurance Marketplace.

Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

For more information on the Individual Mandate, talk with your tax advisor or visit www.healthcare.gov.

Chapter 3: Comprehensive Medical Benefits

In this chapter you'll find:

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

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

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

There are time limits for filing medical plan claims. All medical plan claims must be submitted to the plan within one year from the date of service. No plan benefits will be paid for any claim submitted after this period. For more information see section entitled "when claims must be filed" on page 81.

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

There are time limits for requesting a review after you receive a notice of denial for a claim. For more information see section entitled "request for review of an adverse benefit determination" on page 83.

TIME LIMIT FOR FILING A LAWSUIT

There are time limits for commencing a lawsuit to obtain benefits after a final decision has been reached on a review. For more information see section entitled "limitation on when a lawsuit may be started" on page 86.

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

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
Calendar Year Deductible	**$250 Individual Deductible** **$750 Family Deductible**	
Lifetime Medical Maximum	**None**	
Calendar Year Out-of-Pocket Maximum	If you obtain services from both PPO and Non-PPO Providers, the Out-of-Pocket maximum is $13,000 per person.	
	After Deductible, **$5,500 per person** After the Out-of-Pocket Maximum is met, covered charges are paid at 100% of the Contracted Rate for the rest of the Calendar Year.	After Deductible, **$13,000 per person** After the Out-of-Pocket is met, covered charges are paid at 100% of Non-PPO Fee Schedule (not billed charges) for the rest of the Calendar Year.
Acupuncture **(**Limited to 15 visits per Calendar Year. Maximum does not apply to treatment of mental health or substance use disorders.)	90% of Contracted Rate	60% of Non-PPO Fee Schedule,
Ambulance	**90% Contracted Rate REMSA Ground** ***Air Ambulance 90% of Contracted Rate**	**60% of Non-PPO Fee Schedule** ***Air Ambulance subject to NSA**
Spinal Manipulation Services (Limited to 15 visits per Calendar Year)	90% of Contracted Rate	60% of Non-PPO Fee Schedule
Bariatric Surgery	**NOT COVERED**	
Cataract Surgery	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Colonoscopy • **Screening Over Age 45:** No precertification needed for age 45 and older (1 every 5 years) • **Diagnostic:** Under age 45 requires precertification	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
Dialysis	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Durable Medical Equipment (DME) (requires a prescription)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Emergency Room	After Deductible, 90% of Contracted Rate	After Deductible, 90% of Non-PPO Fee Schedule (subject to NSA)
Glucose Monitors	Covered under the Prescription Drug Plan if purchased from a Network pharmacy. See page 47.	Not covered
Hearing Aids	90% up to a maximum of $800 per ear in a 4 year period, no Deductible applies	
Home Health Care	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Hospice	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Routine Immunizations for adults over age 19	Reimbursed at 100% up to the following allowed amounts (all other routine immunizations are excluded)**:** • **Flu $33** • **Pneumonia $224** • **Shingles $172**	
Inpatient Hospital	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Lab Work	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Lasik Surgery	After Deductible, 90% of Contracted Rate (Lifetime Maximum of $1,5000 allowable per eye)	
Medical Office Visits (including a specialty office visit)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Mental Health (Inpatient and Outpatient care including residential treatment, intensive outpatient treatment and partial hospitalization)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
MRI/MRA/CAT or PET Scan ***Requires precertification**	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Orthotics (must be custom Molded by M.D. or D.O.)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Outpatient Surgery (Requires precertification)	90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Physical Therapy (Dr. orders required)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Maternity (Employee and Spouse ONLY)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Radiology	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Routine Annual Exam Employee and Spouse	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Routine Annual Physical Employee and Spouse with Hometown Health	100% for Annual Physical (includes labs & X-rays)	
Routine Ob/Gyn Exam (including annual Pap Smear and Mammogram)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Second Surgical Opinion	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Skilled Nursing Facility	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Smoking Cessation	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Speech and Occupational Therapy	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Substance Use Disorder - Outpatient (including Intensive Outpatient Treatment and Partial Hospitalization)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule

SCHEDULE OF MEDICAL BENEFITS		
Service	**PPO**	*** Non-PPO**
Substance Use Disorder - Inpatient and Detox	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Telemedicine services for a mental health/substance is covered with all mental health/substance use providers. It is also covered for Renown Rural telehealth when initiated through Renown. All other Telemedicine services will be denied.	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
TMJ	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Urgent Care	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule
Well Child Care (to age 19)	After Deductible, 90% of Contracted Rate	After Deductible, 60% of Non-PPO Fee Schedule

* Services rendered by out of state non-PPO providers, to out of state residents only, 90% of non-PPO fee schedule. Residents of Nevada who seek services from out of state non-PPO providers will remain the same at 60% of non-PPO fee schedule.

How the Plan Works

PPO Providers

Your medical benefits have been structured to encourage you to use a PPO Provider—a Physician, hospital, or other health care professional or facility that has contracted with the Fund to provide services to your and the Fund at a contracted discounted rate. If you use a PPO Provider, you pay only your deductible and your percentage of the PPO rate.

If you use a Non-PPO Provider, the Fund bases its payment for a service or supply on a scheduled allowance. You pay your deductible, a percentage of the Fund's scheduled allowance, plus any amount the provider charges beyond the Fund's scheduled allowance.

For example ... *Let's say you are scheduled for outpatient surgery and you previously satisfied the deductible. The PPO Contracted Rate for the surgical procedure is $800, and the scheduled allowance is $500. If you use a PPO Provider, you pay only 10% of $800, or $80. If you use a Non-PPO Provider, you pay 40% of the $500, or $200, plus 100% of any amount that doctor charges in excess of the $500 scheduled allowance. If the Non-PPO Provider charged $1,000, your share of the costs would be $200 plus the $500 excess, or $700.*

Non-PPO providers are under no obligation to limit their charges to the scheduled allowances. This means that they can bill you directly for any outstanding balance (known as balance billing).

PPO Provider Directory

A list of PPO Providers is available to you without charge from the Administrative Office, or by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Fund. If you obtain and rely upon incorrect information about whether a provider is a network provider from the Fund or its administrators, the Fund will apply Contract cost-sharing to your claim, even if the provider was Non-Contract.

We also recommend that you confirm that your health care provider is currently contracted with the PPO network. Call the Administrative Office at (775) 826-7200 or visit www.oe3health.org to confirm that your provider is contracted so that you can receive the best available benefits.

Patient Protection Rights

The Fund does not require the selection or designation of a primary care provider (PCP) or pediatrician. You have the ability to visit any PPO or Non-PPO Health Care Provider; however, payment by the Fund may be less for the use of a Non-PPO Provider.

You do not need prior authorization from the Fund or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Fund Office or visit www.oe3health.org.

Continuing Care

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

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

Covered Expenses: PPO Contracted Rates and Non-PPO Scheduled Plan Allowances

The Fund contracts with Hospitals, Physicians, Allied Health Care Practitioners and other health care providers. These providers have agreed to PPO Contracted Rates. The Plan bases its payment on the contracted rates according the Provider's contract./

Non-PPO providers have not agreed to PPO rates and the Plan bases its payment on Non-PPO Fee Schedule. For some services, the allowances may be a stated dollar amount or they may be based on the amount that a PPO Provider would accept.

Annual Deductible

The deductible is the out-of-pocket expense you must pay during any one calendar year before the Fund pays benefits. The individual deductible is $250 of Covered Expense incurred in a calendar year, limited to a

maximum of $750 per family during a calendar year. Non-Covered Expenses, including expenses in excess of the scheduled allowances for a Non-PPO Provider, may not be used to satisfy the deductible. Covered Expenses incurred and applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next following calendar year. The deductible does not apply toward the out-of-pocket maximum.

Allowed Charge

The Plan pays a percentage of covered expenses and you pay a percentage as reflected on the Schedule of Medical Benefits beginning on page 21.

- For PPO Providers, the Plan pays a percentage of the PPO Contracted Rate.
- For Non-PPO Providers, the Plan pays a percentage of the Non-PPO Fee Schedule.

Some Hospitals may be PPO only for inpatient services or for specific outpatient services. For Hospital outpatient services, the determination of whether the Hospital will be paid as a PPO Provider or a Non-PPO Provider depends on whether the Hospital is contracted for the services you receive.

Please let the Fund know if the following applies to you: If an Employee receives medical services while temporarily residing out-of-state to perform work for a Contributing Employer, the Fund will pay the PPO Provider a percentage of the Allowed Charges. The Non-PPO Scheduled Plan Allowances for Non-PPO Providers will not apply. Services rendered by an out-of-state Non-PPO Provider, to **out-of-state Residents only**, will be 90% of Non-PPO Scheduled Plan Allowance. If a resident of Nevada seeks services from an out-of-state Non-PPO Provider, the Fund will pay 60% of the Non-PPO Scheduled Plan Allowance.

Out-Of-Pocket Maximum For Covered Medical Plan Expenses

There are limits to the amount of the out-of-pocket expenses for each person (you and each of your Dependents). Once the person has paid $5,500 for PPO Providers or $13,000 for Non-PPO Providers, the Fund pays 100% of Non-PPO Fee Schedule for that calendar year (unless otherwise noted). If a person obtains services from both PPO and Non-PPO Providers, the out-of-pocket maximum is $13,000.

The following are not covered expenses, are not payable even when you reach the out-of-pocket maximum, and do not count toward the out-of-pocket maximum:

- Charges above the Non-PPO Fee Schedule.
- Amounts you pay for non-covered services or supplies or non-covered expenses.

This annual limit on your out-of-pocket payments for covered expenses applies only to comprehensive major medical benefits, not to other benefits discussed in this booklet.

Required Review of Certain Services

Precertification tells you in advance about Plan coverage for certain services. You are responsible for obtaining precertification for certain services, although your Hospital or Physician may obtain it on your behalf. This program consists of the following:

- **Precertification review:** review of proposed health care services before the services are provided;
- **Concurrent (continued stay) review:** ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital;

- **Retrospective review:** review of health care services after they have been provided. If the Plan determines that services or supplies were not Medically Necessary, no benefits will be provided by the Plan for those services or supplies.

The following services must be precertified by the Plan BEFORE the services are provided:

WHAT SERVICES MUST BE PRECERTIFIED BY THE Plan?

- All Elective Hospital admissions. (*Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section*);
- Biopsy's done in an outpatient setting;
- Cardiac catheterizations;
- Cat scan's;
- Chemotherapy;
- Colonoscopy's (for patients under age 45);
- Cyberknife;
- Home Health/Home Physical Therapy/Occupational Therapy and Speech Therapy;
- Home Infusion Therapy;
- Injections or shots that are not provided in a Doctor's office;
- Infusion Therapy/IV Therapy done in a facility or Hospital;
- Inpatient Rehabilitation;
- Inpatient Skilled Nursing;
- Inpatient Surgeries;
- MRI's;
- MRA's;
- Nuclear Medicine Testing;
- Outpatient Surgery;
- Paracentesis;
- Pet Scans;
- Radiation Therapy;
- Referral for a Transplant of any type; and
- Thorancentesis.
- Spinal Cord Stimulators, Trials, and Implants
- Sacroiliac Joint Injection
- Plexus Blocks and Genicular Blocks
- Kyphoplasty and Vertebroplasty
- Pain Pumps

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

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

How to Request Precertification

Amy request for precertification needs to be submitted to the Fund Office with all of the information listed below.

1. Requests for elective services should be made at least 7 days before the expected date of service.
2. The fax should include all of the following information: the Fund's name, Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. If the preservice review process was not properly followed the requester will be notified as soon as possible but not later than 5 calendar days after your request.
4. If additional information is needed, the Plan will advise the requester. The Plan will review the information provided, and will let you, your Physician and the Hospital, and the Fund Office know whether or not the proposed health care services have been certified as Medically Necessary. The Plan will usually respond to your treating Physician by telephone not later than 15 calendar days after it receives the request and any required medical records and/or information, and its determination will then be confirmed in writing.
5. If your admission or service is determined not to be Medically Necessary, you and your Physician will be given recommendations for alternative treatment. You may also pursue an appeal.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the Plan before you are admitted. If this happens, the Plan should be notified of the hospital admission within 48 hours. You, your Physician, the hospital, a family member or friend can fax information to the Fund Office.

Special Provisions Regarding Women's Health Care

Federal law guarantees certain rights to women:

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

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

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

- **Under the Women's Health and Cancer Rights Act of 1998 (WHCRA)**, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedemas. These services are elective and are chosen by the patient in consultation with the attending physician. They are subject to the Plan's usual cost sharing provisions.

Emergency Services

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

The term "Emergency Services" means the following:/

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

Emergency room services are covered:

1. Without the need for any prior authorization determination, even if the services are provided on an out-of-network basis;

2. Without regard to whether the health care provider furnishing the Emergency Services is a Contract Provider or a Contract emergency facility, as applicable, with respect to the services,·

3. Without imposing any administrative requirement or limitation on Non-Contract Provider Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Contract Providers and Contract emergency facilities,·

4. Without imposing cost-sharing requirements on Non-Contract Provider Emergency Services that are greater than the requirements that would apply if the services were provided by a Contract Provider or a Contract emergency facility;

5. By calculating the Cost-sharing requirement for Non-Contract Provider Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and

6. By counting any Cost-sharing payments made by the participant or dependent with respect to the Non-Contract Provider Emergency Services toward any in-network deductible or in-network out-of- pocket maximums applied under the plan (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the Cost-sharing payments were made with respect to Emergency Services furnished by a Contract Provider or a Contract emergency facility.

7. Emergency Services furnished by a Non-Contract Provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the Emergency Medical Condition, until:

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

    b. The participant or dependent is supplied with a written notice, as required by federal

law, that the provider is a non- Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

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

Covered Expenses

- **Physician services**—If you or a covered Dependent requires the services of a Physician for an emergency medical condition within or outside the state of Nevada, benefits are paid at the same level as hospital benefits for emergency medical conditions.
- **Hospital emergency room** use and the supplies, ancillary services, drugs, and medicines listed earlier under "Hospital Services and Supplies."
- **Hospitalization** (including acute care Medically Necessary detoxification)- If you are admitted to a Non-PPO Hospital in an emergency, the Fund will pay the percentage listed in the Schedule of Medical Benefits beginning on page 21. If you decline to transfer to a PPO Hospital after it has been determined to be medically safe, benefits for any services after that point will be paid at the Non-PPO Fee Schedule.
- **Ambulance service**—services of a licensed ambulance for the ground transportation of you or your covered Dependent to a Hospital. A licensed air ambulance is also covered if the Board determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life.

Covered Non-Emergency Services

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

- By calculating the cost-sharing payment as if the total amount that would have been charged for the items and services by such Contract provider were equal to the Recognized Amount for the items and services, and
- By counting any cost-sharing payments made by the participant or dependent toward any in-network deductible and in-network out-of-pocket maximums applied under the plan (and the in-network deductible and out-of-pocket maximums must be applied) in the saine manner as if such cost-sharing payments were made with respect to items and services furnished by a - Contract Provider.
- Non-emergency items or services performed by a Non-Contract Provider at a Contract facility will be covered based on your out-of-network coverage if:
- At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

- The participant or dependent gives informed consent to continued treatment by the Non- Contract Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract Provider may result in greater cost to the participant or dependent.
- The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Contract Provider satisfied the notice and consent criteria, and therefore these services will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a Contract Provider,
- With cost-sharing requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
- With cost-sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such cost-sharing payments were with respect to items and services furnished by a Contract Provider.

Urgent Care Claims

If your Physician recommends a treatment you are not sure is covered by the Plan (for example, a new cancer treatment), your case may qualify for urgent care precertification if waiting more than several days to have the treatment:

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

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

You should fax the proposed treatment to the attention of the precertification representative at (775) 826-7289, requesting approval of the benefit in advance.

See “Claims Review Procedures” in Chapter 12 for more information about urgent care claims, including time frames for response.

Cash Incentive for Recovering Hospital Overcharges

If you discover an overcharge on your hospital bill and negotiate with the hospital to have it corrected, the Fund will pay you 25% of the amount recovered.

For you to be eligible, the hospital overcharges must total $25 or more in a calendar year. Only hospital expenses covered under the Plan will be considered. Expenses such as telephone bills, television rental, newspapers, etc., that are not Covered Expenses under the Plan will not be considered**.** Please note that the per diem rates at contracting hospitals are an all-inclusive rate and are not subject to negotiation.

If you are covered by more than one health plan, you are eligible only if the Northern Nevada Operating Engineers Health and Welfare Trust Fund plan is the primary plan (see "Coordination of Benefits" in Chapter 12 for a discussion of which plan is primary).

You will receive 25% of the amount the hospital agrees is invalid as a result of direct negotiations between you and the hospital, up to a maximum of $1,000 in any calendar year.

To claim your cash incentive, send the Administrative Office the following documents within 45 days of the date of discharge from the hospital:

- A copy of the initial itemized hospital bill with the overcharges circled and
- A copy of the adjusted bill showing that the hospital agreed to reduce its billing by the amount of the overcharges.

Covered Services and Supplies

Covered services and supplies include those described below. Exclusions and limits that apply to specific services and supplies are described with those services and supplies; others are described in the "Exclusions from Coverage" that follow the covered services and supplies.

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

Hospital Services and Supplies

You may want to call the Administrative Office at (775) 826-7200 to make sure the hospital you are planning to use is a PPO Hospital. See also "Cash Incentive for Recovering Hospital Overcharges" above.

Inpatient Hospital Charges

- Accommodations in a semi-private room, including cardiac care units and intensive care units
- Routine nursery care furnished to a newborn baby while the mother is also confined in the Hospital
- Use of operating, delivery, and cystoscopic rooms
- Supplies
- Ancillary services, including laboratory, cardiology, pathology, and radiology and any professional component of these services
- Anesthesia
- Physical therapy
- Oxygen
- In a PPO Hospital, drugs and medicines approved for general use by the Food and Drug Administration that are supplied by the hospital for the Illness, Injury, or condition for which the eligible individual is hospitalized, including take-home drugs dispensed by the hospital's pharmacy at the time of discharge

- In a Non-PPO Hospital, drugs and medicines approved for general use by the Food and Drug Administration that are supplied by the hospital for use during the eligible individual's stay
- Blood transfusions, including the cost of unreplaced blood, blood products, and blood processing

Pre-Op Testing at Renown Facilities

If you are scheduled for inpatient surgery, you may get your Pre-op testing (labs, x-rays and EKG) at the respective hospitals 3 days prior to surgery and the charges will be part of your hospital bill. Call Pre-Op scheduling or go online to schedule your Pre-Op Testing. If the inpatient Pre-Op testing is done more than 3 days prior to surgery, you and the Fund may be billed separately and incur additional costs.

If you are having outpatient surgery, you may get your Pre-op testing (labs, x-rays and EKG) at the respective hospitals on the day of your outpatient surgery. Call Pre-Op scheduling or go online to schedule your Pre-Op Testing. If the outpatient Pre-Op testing is done prior to the date of the surgery, you and the Fund may be billed separately and incur additional costs.

Observation Short Stay

There are times that you may be assigned to a hospital bed for diagnostic watching or observation during which time you do not receive any therapeutic or surgical intervention. If this observation short stay lasts after the hour of midnight, the observation short stay is considered an inpatient stay, and the Hospital will be reimbursed at the appropriate inpatient rate for all services rendered after the hour of midnight for this type of inpatient confinement. All of the following days will also be considered at the appropriate inpatient rate.

This means that the Hospital may bill for an observation short stay which will be reimbursed by your Plan as an inpatient admission. The difference in the hospital designation of level of care that the level of care covered by your Plan may result in non-covered charges for which the patient may be responsible.

Exception: Renown Medical will be paid according to the contract rather than as outlined above. Please contact the Fund Office with any questions.

If you have these services, and do not understand your patient liability when you get your Explanation of Benefits, please contact the Trust Fund Office.

Hospital Outpatient Services

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

- Emergency room services
- Trauma Center
- Facilities for the following major procedures:
  - Cardiac catheterization.
  - Phlebotomy services required to be done in an acute care facility.
  - Blood transfusions.
  - Diagnostic procedures requiring an acute care facility.
- Outpatient surgery (precertification required)
- Other laboratory, x-ray, imaging and other diagnostic procedures.

Some Hospitals are considered to be PPO Hospitals only for inpatient services and are not considered to be PPO Hospitals for any outpatient services. Some Hospitals are considered to be Non-PPO Hospitals only for inpatient services and are considered to be PPO Hospitals for certain outpatient services.

Skilled Nursing Facility or Other Specialized Facility

Conditions of eligibility for benefits are as follows:

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

Covered Expenses

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

Doctor Visits

Covered Expense

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

Not covered

- More than one home or office "visit" per day by a Physician (the term "visit" means a personal interview between you and the Physician and does not include telephone calls or other situations where you are not personally examined by a Physician or allied health care professional).
- Prenatal care for the pregnancy of a Dependent daughter.

X-Ray and Laboratory Services

Covered Expense

Outpatient diagnostic radiology and laboratory services (CT/Pet Scan and/or MRI require precertification prior to testing).

Covered services may include laboratory testing or other diagnostic testing (including but not limited to hematological and radiological studies) ordered by a Physician to determine evidence-based diagnosis for the cause of pain, and/or any laboratory testing or other diagnostic testing ordered by a Physician for the determination of the presence of controlled substances in the patient.

Limitation

- For a Non-PPO Provider performing only the professional component (Modifier 26), the Allowed Charge is 40% of the scheduled allowance (unless otherwise covered by NSA).

NOTE: For most diagnostic procedures, you can save money by choosing a free-standing facility instead of the outpatient department of a hospital.

See "Preventive Care" later in this section for information on coverage of mammograms, Pap smears, and PSA tests.

Not Covered

- Genetic Testing is not covered, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics.

Second Surgical Opinion

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

Covered Expense

- A second surgical consultation obtained for the purpose of determining the necessity for prescribed elective surgery

Surgery

Covered Expenses

- Surgery by a primary operating Physician or assisting surgeon. Services by a second Physician or surgeon on the same case at the same time when the attendance is warranted by a need for supplementary skills.

  Preoperative and Postoperative Care: Benefits will be based on the "Surgery Value Guidelines" as outlined in the *Relative Values for Physicians*, as updated.

  Procedure for Multiple Surgical Codes: 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 as outlined in the paragraph below 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.

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

Exception: Renown will be paid according to the contract rather than as outlined above. Please contact the Fund Office with any questions.

For Hospitals and Surgical Centers, the same order of determination will be applied with the exception of limiting it to maximum payable of two procedures. These claims will follow the same order as the surgeon and will allow the exact same CPT codes being billed in the same exact order as the surgeon's claim. The Add-on codes and Modifier Exempt codes are not exempt to being cutback, and are still limited to the maximum of 2 procedures with the 1st being allowed @100% and the 2nd procedure allowed at 50% per Plan benefits:

- 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 surgery for the facility.
- 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 surgery for the facility.

Exception: Renown will be paid according to the contract rather than as outlined above. Please contact the Fund Office with any questions.

- For an Employee or Spouse, obstetrical services, operations for ectopic pregnancy or miscarriage.
- Consistent with the Women's Health and Cancer Rights Act of 1998, reconstruction of the breast on which a mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.
- Services of a Registered Nurse First Assistant (RNFA), Physician's Assistant (PA), Certified Orthopedic Technician (COT), or Certified Surgical Assistant (CSA) in lieu of an assistant surgeon are allowed at 15% of the allowance for the primary surgeon.
- Services of an anesthetist. (When regional or general anesthesia—not including local infiltration anesthesia—is provided by a primary operating or assisting Physician, the Covered Expense is determined by the "basic" value for anesthesia without added value for time).
- Organ and tissue transplant surgery for cornea, bone marrow, kidney, heart, heart-lung, liver and pancreas as described in the section entitled "Transplants."
- Lasik surgery up to the amount outlined in the chart at the beginning of this Chapter.

Not Covered

- Surgery solely for cosmetic purposes or other services for beautification, except:
  - ✓ To correct congenital anomalies,
  - ✓ To correct functional disorder,

- ✓ As a result of a covered Injury, for services performed within 12 months of such injury (applied without respect to when the individual is enrolled in the plan), or

- Transportation of surgeons or family members.
- For Dependent daughters, expenses for pregnancy, except for Complications of Pregnancy.

Maternity and Reproductive Services

The Fund pays benefits as noted below for Covered Expenses.

NOTE: Pregnancy-related benefits for Dependent daughters are limited to treatment of Complications of Pregnancy, as defined in the glossary at the end of this SPD.

Covered Expense

- Obstetrical services, including operations for extrauterine pregnancy, miscarriage on the same basis as other surgery
- Prenatal care on the same basis as other Physician services (for Employee and Spouse)
- Hospital stay for mother and newborn on the same basis as other hospital stays

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

Not Covered

- A Dependent daughter's pregnancy or maternity care, except for Complications of Pregnancy
- Abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion
- Services to reverse voluntary surgically induced infertility
- In vitro fertilization, artificial insemination, or any other surgical services to induce pregnancy or related to infertility or any drug therapy or other services to induce pregnancy
- Treatment related to a surrogate pregnancy in which the Employee and/or Dependent acts as 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 to any and all complications related to the surrogate pregnancy. For the purpose of this Plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse.

See Chapter 4, "Prescription Drug Benefits," for information on benefits for contraceptives.

Preventive Care

The Fund pays benefits as noted below for Covered Expenses.

Covered Expense

- Physical examination **(available only for you and your Spouse, not your Dependent Children)**—The Fund will reimburse you for expenses for a routine physical examination performed by a Physician, including expenses for radiology (including a coronary calcium scoring CT scan) and laboratory testing, once per calendar year
- Annual routine Pap smear and pelvic examination
- Adult Immunizations (not subject to Deductible or Coinsurance):

- Up to $33 for a flu shot;
- Up to $224 for a Pneumococcal vaccine
- Up to $172 for a Shingles vaccine

- Annual routine mammogram for women age 35 and older
- Preventive care colonoscopy once every five years (no precertification is needed for age 45 and older)
- Well-child care (billed as an encounter for routine child health exam) including routine diagnostic testing or routine childhood vaccinations up to age 19 (including any COVID-19 vaccine or booster), in accordance with the "Recommendations for Preventive Pediatric Health Care" published by the American Academy of Pediatrics
- **For the Employee only:** Commercial Driver's License (CDL) examination performed by Eric P. Osgood, D.C., when billed as a routine physical examination

Not Covered

- Physical examinations for Dependent children except as described as Well Child Benefit
- Routine eye examinations for visual acuity except as described under Vision Benefit
- Any examination required by an employer as a condition of employment (except for the CDL exam outlined above)

Physical Exam Benefit for Employee and Spouse

This routine physical exam is <u>in addition</u> to the current physical exam benefit that is available with your primary care physician. The routine physical exam with Hometown Health will include:

- Personal and family medical history, health conditions and lifestyle risks;
- Lab screening includes FIT test for blood in stool, urinalysis, and blood work for complete blood count with differential, comprehensive metabolic panel, lipid panel, Thyroid Stimulating Hormone (TSH) and for males over age 45, a Prostate Specific Antigen (PSA);
- Hearing and vision screening;
- Pulmonary function testing and oxygen saturation to assess lung health;
- Resting Electrocardiogram (ECG) to assess heart rate and rhythm;
- Two-view chest x-ray when applicable (history of smoking, asbestos exposure, woodworking);
- Executive summary mailed to you and your primary care physician.

Please note that a registered nurse will be available for telephone follow-up if you have questions after your physical. To schedule an exam with Hometown Health, please contact the number on the Quick Reference Chart.

Please identify yourself as a member of the Northern Nevada Operating Engineers Health and Welfare Trust Fund when you call.

For women who would prefer to have a pelvic exam, a cervical cancer screening (Pap smear), mammogram and DEXA scan can be scheduled on the same date. Hometown Health will bill the Trust Fund and normal benefits will be payable.

Transplants

All transplants require precertification. The Fund will pay regular Plan benefits for covered transplant expenses, provided the transplant is not considered experimental or investigational and the transplant is performed in a transplant center program in a major medical center approved either by the Federal government or the appropriate state agency of the state in which the center is located.

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

- Cornea;
- Bone marrow;
- Kidney;
- Heart;
- Lung;
- Liver; and
- Pancreas.

Please note: Expenses for or related to gene therapy (a technique that uses human genes to treat or prevent disease in humans which can include introducing human DNA genetic material into an individual to treat or prevent a disease or correct a faulty/missing gene) are not covered.

Covered Expense

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

Treatment of Vertebrae, Spine, Back, or Neck

If you use a Non-PPO Provider, coverage is limited to one session per calendar day (either one visit and up to two modalities of treatment, or up to three modalities of treatment).

Covered Expense

- Treatment of the vertebrae, spine, back, or neck by a Physician, chiropractor, or other licensed practitioner, for up to 15 visits per calendar year for all conditions combined.

Mental Health

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

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

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

Covered Expenses

- **Inpatient Treatment**
- **Outpatient Treatment**. Psychotherapy and psychological testing provided by a covered practitioner practicing within the scope of his or her license.
- **Recovery Home/Halfway House/Residential Treatment Program**
- **Diversion/Education**
- **Telemedicine Services** for treatment of a mental health and/or substance use disorder

Substance Use Disorder Treatment

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

Covered Expense

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

Home Health Care and I.V. Therapy

Benefits for home health care or home I.V. therapy will not exceed those that would have been payable if services were performed in a hospital or skilled nursing facility or other specialized facility. Benefits for home health care or home I.V. therapy require precertification by the Plan.

Covered Expenses

- Home health care or home I.V. therapy that would have been covered under the Plan if services were performed in a hospital or skilled nursing facility or other specialized facility and that meets all of the following requirements:
    - Services are prescribed by a Physician to be performed in your home and are medically necessary;
    - Services are for care and treatment of an Illness or Injury immediately following a period of confinement in a hospital or skilled nursing facility or other specialized facility and are provided in lieu of confinement;

* Services are performed by or under the supervision of a person or agency that is licensed, certified, or otherwise qualified to perform such services on the same basis as if the services had been performed in a hospital or skilled nursing facility or other specialized facility; and
* Periodic recertification of the necessity for such services and prognosis reports are furnished by the home health care agency and/or the Physician when requested by the Fund.

Not Covered

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

Hospice Care

Benefits are payable for hospice care provided by an approved hospice program (including inpatient hospice care and outpatient home hospice up to a lifetime maximum of 30 days). In order for hospice care to be covered, the patient must be terminally ill (with a life expectancy of 6 months or less).

Covered Expense

- Nursing services by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.)
- Medical social services by a person with a Master's degree in social work.
- Home health aide.
- Medical supplies (normally used by a Hospital during an inpatient confinement and dispensed by the hospice agency.
- Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

Not Covered

- Transportation.
- Services of volunteers.
- Food, clothing or housing.
- Services provided by household members, family, or friends.
- Services of financial or legal counselors.

Hearing Aids

The Fund will reimburse you for up to a maximum benefit of $800 per hearing aid device.

Covered Expense

- A hearing examination performed by a Physician and placement of a hearing aid device
- Hearing aid device (limited to one device per ear during any 4-year period)

Durable Medical Equipment (DME), Prostheses, and Orthotics

Covered Expenses

- Rental or purchase of medical equipment and supplies that are ordered by a Physician, are manufactured specifically for medical use, are of no further use when the medical need ends, are usable only by the patient, and are approved as effective and reasonable treatment of a condition, as determined by the Board

- Oxygen and rental of equipment for its administration (small or large)
- Fees incurred for maintenance agreements related to the purchase of oxygen concentrators
- Artificial durable devices or equipment that replaces all or part of a bodily organ or that improves the function of an impaired bodily organ (including prostheses following a mastectomy), except dental appliances, which are not covered under medical benefits
- Blood glucose meters for diabetes
- Custom-molded orthotics when provided by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or podiatrist (D.P.M.) or by a Durable Medical Equipment licensed provider when ordered by a M.D., D.O. or D.P.M. for treatment of the feet

Not Covered

- Rental or purchase of equipment that is primarily for the comfort or hygiene of the patient, is for environmental control, is for exercise, or is for prevention purposes
- Rental charges that exceed the reasonable purchase price of the equipment
- Expenses for repairs of custom-molded orthotics
- Replacement of prostheses except in cases of clearly demonstrable medical necessity due to significant clinical change in the functional status of the patient or if the prosthesis becomes nonfunctional due to normal, predictable wear and tear that cannot be repaired

Acupuncture

Covered Expenses

- Medically necessary treatment by a licensed acupuncturist for up to 15 visits per calendar year (calendar year limits will not apply to Medically Necessary treatment of mental health or substance use disorders).

Smoking Cessation Program

This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco). Normal plan benefits apply.

Covered Expenses

- Office visits with a covered Healthcare Practitioner
- Participation in a smoking cessation program
- Prescription drugs for smoking cessation
- Over-the-counter smoking cessation treatments

Additional Services and Supplies

Covered Expenses

- **Dialysis treatment**. Regular Plan benefits are payable for dialysis treatment prescribed by a Physician. The applicable percentages will apply to the Contracted rate for PPO Providers and to the Scheduled Plan Allowances for Non-PPO Providers. Should the amount billed be less than the Non-PPO Schedule Allowable, the amount allowed shall not exceed the billed charge. For any service not itemized on the Non-PPO Fee Schedule, a fee will be established at current Medicare Allowable charges. All fees subsequently established will be added to the Non-PPO Fee Schedule for Dialysis Services.

- **Temporomandibular Joint (TMJ) Syndrome.** Regular Plan benefits for treatment of TMJ are payable.
- Services of a registered nurse or licensed vocational nurse when these services are medically necessary and approved by the Board of Trustees.
- Services of a **registered physical therapist** required for Medically Necessary treatment of an illness or injury (including autism) and prescribed by a Physician.
- **Surgical dressings, splints, casts**, and other devices for reduction of fractures or dislocations.
- **Blood transfusions,** including blood processing and the cost of unreplaced blood and blood products.
- **Radiation therapy and chemotherapy.**
- **Trigger point injections** for up to five trigger point injections per visit (limited to one visit per day) and a maximum of 15 visits per calendar year.
- **Two support hose stocking** are covered per calendar year if Medically Necessary and supported by doctor's orders.
- Following cataract surgery, the **first lens replacement** is covered.
- Home **sleep studies** if Medically Necessary.
- **Shoes and inserts** based on Medical Necessity and Doctor's orders for patients diagnosed with diabetes.
- **Continuous glucose monitors** (payable under the Prescription Drug Plan) based on Medical Necessity for patients with diabetes.

Not Covered

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

Exclusions from Coverage

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

- Any expenses that exceed the PPO Contracted Rate or the Non-PPO Fee Schedule or for services and supplies that are not deemed "medically necessary," or are incurred by you or a Dependent on a date you are not covered by the Plan (an expense is deemed to have been incurred on the date the person receives the service or supply for which the charge is made).

  Definitions of "Medically Necessary," "Allowed Charge," and other terms used in this section can be found in the glossary at the end of this SPD.

- Any services or supplies listed as "Not Covered" in relation to specific benefits earlier in this chapter.
- Services for which benefits are payable under any other programs provided by the Fund.
- Any course of treatment, whether or not prescribed by a physician, for which charges incurred are not the direct result of an Injury or Illness, any procedure not recognized to have medical significance or therapeutic value, and/or any course of treatment making use of drugs or devices that are experimental or investigational (see the glossary at the end of this SPD for definitions of "experimental" and "investigational").
- Experimental treatment (see the glossary at the end of this SPD for a definition of "Experimental").
- Services furnished by a naturopath or any other provider not meeting the definition of Physician or other allied health care professional (see the glossary at the end of this SPD for a definition of "Physician").

- (*If this Plan is secondary when coordinating benefits with another plan that has entered into a preferred provider agreement with a medical or hospital provider*) Any amount exceeding the difference between the normal charges billed for the expenses by the provider or the contractual rate for such expense under the preferred provider agreement (whichever is less) and the amount that the other plan pays as primary (*This exclusion is in addition to any other limits generally applicable to this Plan or its coordination of benefit provisions*).

- Charges for well-child care, routine physical examinations for Dependents over age 19 except as specifically provided in the Plan or discussed earlier in this chapter.

- Outpatient prescription drugs (*see Chapter 4,"Prescription Drug Benefits," for information on coverage of prescription drugs*)

- Custodial care or rest cures; services provided by a rest home, a home for the aged, a nursing home, or any similar facility; or custodial hospital care

- Dental plates, bridges, crowns, caps, or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except treatment for tumors or cysts or treatment necessary to repair or alleviate damage to teeth as a result of an accident, not an injury due to biting or chewing (*see Chapter 5, "Dental Benefits", for information on coverage of such benefits)*

- Eye refractions or eyeglasses or eyeglass fitting (*see Chapter 6, "Vision Care Benefits," for information on coverage of such benefits*)

- Any surgical procedure to correct nearsightedness or farsightedness except as otherwise provided under the Lasik surgery benefit.

- Expenses for transportation of physicians or family members

- Any services or supplies excluded under "General Exclusions, Limits, and Reductions" in Chapter 12

- Injuries an individual inflicts on himself, attempted suicide, or drug abuse unless the suicide attempt or the drug abuse arises as a result of a physical or mental health condition or if a victim of domestic violence. The Fund 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.

- Treatment related to a surrogate pregnancy in which the Employee and/or Dependent acts as 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 to any and all complications related to the surrogate pregnancy. For the purpose of this Plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her Spouse. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for a medical Emergency as defined in the Definitions chapter of this document.

- Educational services.

- Hypnotism, stress management, biofeedback and any goal-oriented behavior modification therapy (unless otherwise specifically covered) such as to lose weight or control pain.

- Court ordered anger management therapy.

- Services provided primarily for weight reduction or treatment of obesity. However, Medically Necessary Behavioral Health counseling for an eating disorder is covered.

- Services related to sexual reassignment, transsexual operations or any resulting medical complications.

- Expenses for or related to gene therapy (a technique that uses human genes to treat or prevent disease in humans which can include introducing human DNA genetic material into an individual to treat or prevent a disease or correct a faulty/missing gene).

- Expenses related to genetic testing including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities or genetically transmitted characteristics.

How to File a Claim for Medical Benefits

NOTE: The discussion below applies to "post-service claims"—claims you submit after you have received a service. The following are also considered claims: requests for expedited approval in cases meriting treatment as urgent care claims and decisions regarding treatment in progress. See "Urgent Care Claims" earlier in this chapter and "Claims Review Procedures" in Chapter 12 for more information.

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

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

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, forms supplied by hospitals and physicians are usually acceptable substitutes for claim processing.*)

- Complete your portion of the form, including information about other coverage

- Have the person providing services complete the rest of the form.

- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:

    - Your (the Employee's) name and Social Security number

    - The patient's name and date of birth and relationship to you

    - The date of service

    - The CPT-4 codes—the codes for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association

    - The ICD codes—the diagnosis codes found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services

    - The billed charge(s)

    - The number of units (for anesthesia and certain other claims)

    - The Federal taxpayer identification number (TIN) of the provider

    - The billing name and address

If medical services were rendered because of an accident, the date and place of the injury, including details (i.e., automobile accident, fall, etc.)

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

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

NOTE: You must submit your claim **within 90 days** from the date on which Covered Expenses were incurred, unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than 1 year after the date on which Covered Expenses were incurred. If you have any questions about submitting your claim, contact the Administrative Office.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 12, "Other Important Plan Information."

If You Have Other Insurance

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

The form (the "other insurance inquiry form" which members are required to complete, sign, and submit to the Administrative Office at least once each calendar year) asks you whether you have other insurance. By entering the requested information on the form, you take care of your notification responsibility. Claims will be denied if the Fund Office does not receive a response.

Chapter 4: Prescription Drug Benefits

In this chapter you'll find:

- A quick-reference guide to prescription drug benefits
- How the Plan works
- Copayments at retail pharmacies
- Mail order service
- Covered drugs and supplies
- Exclusions from coverage
- Information on filing claims

When a doctor or dentist prescribes a medicine for you or a covered Dependent, your outpatient prescription drug benefits will pay 100% of reasonable covered charges after you pay a "copayment." Your prescription drug benefits also include a mail service program for home delivery of maintenance drugs (those taken on a regular or long-term basis) at a reduced cost.

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

Prescription Drug Benefits	
General Plan Features	
Calendar-year deductible	None (although the per-prescription copayments are sometimes called "deductibles")
Calendar-year limit on your copayments	None

Benefits for Covered Prescription Drugs	
If you fill your prescription at a retail pharmacy	You pay a copay of: ✓ $15 for up to a 34-day supply of a formulary generic drug ✓ $25 for up to a 34-day supply of a brand-name drug if no generic is available or your physician specifically requests the brand-name drug. The Fund covers remaining cost *Certain drugs are covered for a supply limit of up to 100 tablets.*
Glucose Monitors	$25 copay if obtained from a Network pharmacy

Benefits for Covered Prescription Drugs	
If you order your prescription through the mail order service	You pay a copay of: ✓ $5 for up to a 90-day supply of a generic drug ✓ $45 for up to a 90-day supply of a per brand name drug if a generic, clinically equivalent. lower-cost substitute 1s unavailable or if the physician specifically requests a brand name drug. ✓ Brand name or non-formulary generic drugs are not covered when a generic, clinically equivalent, lower cost option is available, unless the physician specifically requests the brand· name/non-formulary generic drug as the generic is medically inappropriate. The Fund covers remaining cost.
Specialty Drugs	You pay a copay of: ✓ $15 for up to a 30-day supply of a generic drug ✓ $30 for up to a 30-day supply of a brand-name name drug ✓ $25 per brand name drug if a generic substitute is unavailable or if the physician specifically requests a brand name drug. Fund covers remaining cost. Certain oral chemotherapy prescription drugs qualifying for the Smart Fill program will be covered during the initial three months of treatment for up to a 17-day supply at half of the above listed applicable regular copayment. Eligible Individuals taking prescription drugs in certain therapeutic classes will, after six months, be given the option to fill these prescriptions at up to a 90-day supply for three times the above listed applicable regular copayment.

How the Plan Works

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

- The discounted prices keep Plan costs down for everyone.
- You don't have to worry about submitting a claim for reimbursement—you pay your copayment at the time of purchase, and that's it. The pharmacy bills the Fund for the remaining cost.

You must identify yourself as being covered through the Northern Nevada Operating Engineers Health and Welfare Trust Fund. **Take your OptumRx prescription drug ID card with you** and present it at any network pharmacy when you have a prescription filled.

It is not necessary that each Dependent have an ID card. Just be certain that whoever is getting a prescription filled has an ID card with him or her at that time.

If there is an emergency situation where you find yourself in need of a prescription but without your ID card, be sure to tell the pharmacist that you are insured through the Northern Nevada Operating Engineers Health and Welfare Trust Fund.

If you need to use a non-contract pharmacy, you will have to pay the full cost of the prescription at the time of purchase, then submit a claim for reimbursement with the Administrative Office.

PPO Provider Directory

The PPO Provider directory is updated periodically and is provided to you without charge. If you are not sure you have the most recent copy, contact OptumRx. We also recommend that you call to confirm that a pharmacy you are intending to use is currently a network pharmacy.

Benefits at Retail Pharmacies

If you purchase your drugs at a network retail pharmacy, you pay the required copayments shown in the chart "Benefits for Covered Prescription Drugs." If you do not use a network pharmacy, covered expenses are limited to the average wholesale price of the drug less a discount of 11% plus $2.25. You are responsible for the copayment. You are also responsible for any charges that exceed what the Fund allows.

Prescriptions filled at a retail pharmacy cannot exceed a 34-day supply (except as noted immediately below). Copayments are the same, whether your supply is for 1 day or 34 days.

Exceptions to Supply Limit

The Fund will reimburse charges for up to 100 tablets of any of the following drugs supplied at any one time by a licensed pharmacist:

- Nitroglycerine;
- Oral anti-diabetic drugs;
- Phenobarbital; and
- Thyroid U.S.P.

Mail Order Service

Your prescription drug benefits include mail order service for maintenance drugs (those taken on a regular or long-term basis). You can order such drugs through American Diversified Pharmacies (ADP).

If you purchase your drugs through the mail service, you pay the required copayments shown in the chart "Benefits for Covered Prescription Drugs." You save money because you can get a 90-day supply of your maintenance drugs for just two copayments.

First-time Prescriptions

If you need to start your maintenance medication right away, have your physician write two prescriptions, one for a 34-day supply and one for a 90-day supply with up to three refills. Have the prescription for a 34-day supply filled at a retail pharmacy, and send the prescription for a larger supply to ADP. Your physician can also fax the prescription to ADP at (800) 568-2174.

Make sure your physician writes legibly and includes his or her name, phone number, and DEA number; the drug's name; the strength of the drug; the quantity to be dispensed; and the exact daily dosage.

Fill out the mail order paperwork as indicated and send it with the original prescription and your copayment or payment information (e.g., credit card information) to the address shown on the mail order form.

Refills

You can order refills by phone by calling ADP toll-free at (877) 889-3402. Make sure you have the label from the prescription you are refilling handy for reference during your call.

You can also order refills by mail, using the reorder information sent with each shipment.

Covered Drugs and Supplies

Covered expenses include charges for the following:

- Drugs prescribed by a physician or dentist and dispensed by a licensed pharmacist
- Insulin and insulin injection kits purchased from a licensed pharmacist
- Drugs or insulin or insulin injection kits that are supplied to you or a covered Dependent in the physician's or dentist's office and are charged separately from any other item of expense
- Drugs or insulin or insulin injection kits supplied by a hospital that are for use outside the hospital in connection with treatment received in the hospital, provided they are prescribed by your physician or dentist
- Compounded dermatological preparations prescribed by a physician and dispensed by a licensed pharmacist
- Therapeutic vitamins, cough mixtures, antacids, and eye and ear medications prescribed by a physician for the treatment of a specified Illness and dispensed by a licensed pharmacist
- Vitamins that require a prescription
- For the Employee and the Employee's lawful spouse, oral and injectable contraceptives and devices that require a physician's written prescription or a physician office visit
- New drugs approved by the Federal Food and Drug Administration (if not otherwise excluded from coverage)
- Prescription drugs for smoking cessation and over-the-counter smoking cessation treatments
- Blood Glucose monitors and certain insulin pumps if purchased from a network pharmacy

Exclusions from Coverage

No outpatient prescription drug benefits are provided for the following:

- Drugs you or a Dependent takes or is administered while in the hospital
- Patent or proprietary medicines not requiring a prescription (except insulin)
- Appliances, devices, bandages, heat lamps, braces, or splints (except as specifically covered)
- Vitamins that do not require a prescription, cosmetics, dietary supplements, or health and beauty aids
- Any filling or refilling of a prescription for drugs in excess of the supply limits mentioned above
- Any services or supplies excluded under "General Exclusions, Limits, and Reductions" in Chapter 12

How to File a Claim For Prescription Drug Benefits

If you use a network pharmacy, you pay only your copayment at the time of purchase, so you do not need to worry about filing claims. If you use a non-network pharmacy, you can file a claim for reimbursement by following these steps:

- Obtain a claim form from the Union or the Administrative Office or from www.oe3health.org.
- Complete your portion of the form.
- Have the pharmacy complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
    - Your (the Employee's) name and Social Security number
    - Name and address of the individual for whom the drug was prescribed
    - Birth date of the individual for whom the drug was prescribed and that individual's relationship to you
    - Name, address, and tax ID number of the dispensing pharmacy
    - Date each prescription was dispensed and cost of each prescription
    - The billing name and address
- Mail your claim form with your itemized bills to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

NOTE: You must submit your claim **within 90 days** from the date on which Covered Expenses were incurred, unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than one year after the date on which Covered Expenses were incurred.

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 12, "Other Important Plan Information."

Information About Medicare Part D Prescription Drug Plans For People With Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the prescription drug coverage outlined in this document is "creditable."** "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late penalty under Medicare. You may, in the future, enroll in a Medicare Part D Prescription Drug Plan (PDP) during Medicare's annual enrollment period (generally October 15 through December 7th of each year).

You can keep your current medical and prescription drug coverage with this Plan and you do not have to enroll in Medicare Part D. If however you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan (PDP) you will have dual prescription drug coverage and this Plan will coordinate its drug payments with Medicare. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan (PDP) you will need to pay the Medicare Part D premium out of your own pocket.

Note that you may not drop just the prescription drug coverage under this Plan. That is because prescription drug coverage is part of the entire medical plan.

Medicare-eligible people can enroll in a Medicare Part D Prescription Drug Plan at one of the following 3 times:

- When they first become eligible for Medicare; or
- During Medicare's annual election period (generally October 15th through December 7th); or
- For beneficiaries leaving union group health coverage, you may be eligible for a special enrollment period in which to sign up for a Medicare Part D Prescription Drug Plan.

If you do not have creditable prescription drug coverage and you do not enroll in a Medicare Part D Prescription Drug Plan when first offered that enrollment opportunity, you may have a late enrollment fee on the premium you pay for Medicare coverage if and when you do enroll.

For more information about creditable coverage or Medicare Part D coverage see the Fund's Medicare Part D Notice of Creditable Coverage (a copy is available from the Administrative Office). See also: www.medicare.gov for personalized help or call 1-800-MEDICARE (1-800-633-4227).

Chapter 5: Dental Benefits

In this chapter you'll find:

- A quick-reference guide to dental benefits
- How the Plan works
- Maximum benefits
- Covered services
- Exclusions from coverage
- Information on filing claims

Dental Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may elect/decline Dental Plan benefits annually. Even though the Fund is not required to do so, it has extended dental coverage for Dependents up to age 26.

Your dental benefits provide coverage for services ranging from checkups and cleanings to dentures. The Plan also provides benefits for orthodontic care for eligible Dependent children under age 26.

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

Dental Benefits	
General Plan Features	
Maximum calendar year benefit	$2,500 per individual (Maximum does not apply to Dependents up to age 19).
-Maximum lifetime benefit for orthodontia	$2,500 per individual Orthodontic benefits are available only to your Dependent children under age 26.
Calendar year deductible	None

Benefits for Covered Services and Supplies		
	PPO Providers	**Non-PPO Providers**
Diagnostic care: • **Oral examination (2 per calendar year)** • **Bite-wing X-rays (2 per calendar year)** • **Full-mouth X-rays (once during any period of 3 consecutive years)** • **Emergency palliative treatment** • **Specialist consultation**	90% of the PPO Contracted Rate	80% of the applicable amount shown in the Non-PPO Schedule of Dental Allowances

Benefits for Covered Services and Supplies		
Preventive care: • **Cleanings (2 per calendar year)** • **Fluoride treatment (2 per calendar year) to age 14** • **Application of sealants for Dependent children to age 14 (molar teeth only limited to one per year per tooth)**	90% of the PPO Contracted Rate	80% of the applicable amount shown in the Non-PPO Schedule of Dental Allowances
Basic Services and Restorations • **X-rays (other than bitewing X-rays), study models, space maintainers** • **Oral surgery** • **Fillings (could be downgraded)** • **Endodontics—treatment of the tooth pulp, including necessary X-rays and cultures** • **Periodontics—treatment of gums and bones supporting teeth** • **Single Standing Crowns and other restorative services (replacement is covered only once every 5 years)**	90% of the PPO Contracted Rate	80% of the applicable amount shown in the Non-PPO Schedule of Dental Allowances
Major Services • **Fixed Bridges, Partial and Complete Dentures** • **Construction or repair of fixed bridges or partial or complete dentures** • **Relines and rebases**	60% of the PPO Contracted Rate	60% of the applicable amount shown in the Non-PPO Schedule of Dental Allowances
Night Guards (for bruxism only)	90% of the PPO Contracted Rate	80% of Non-PPO Scheduled Allowance
Dental Implants	60% of the PPO Contracted Rate	60% of the applicable amount shown in the Non-PPO Schedule of Dental Allowances
Orthodontic Services		
All-inclusive orthodontic care (for Dependent children up to age 26)	Fund pays 100%, up to maximum lifetime benefit of $2,500. Banding fees are limited to $500 maximum.	

How the Plan Works

Your dental benefits have been structured to provide an incentive for you to use a PPO Provider—a dentist that has contracted with the Fund to provide services at a Contracted Fee. Benefit payments are based on the PPO Contracted Rate.

If you use a Non-PPO Provider, benefit payments are based on the Non-PPO Fee Schedule for Covered Expenses. Non-PPO dentists are under no obligation to limit their costs to the Non-PPO Fee Schedule. This

schedule is amended from time to time. If you have a question about the allowable amount for a specific service, you can call the Administrative Office.

Maximum Benefits

The Fund pays up to $2,500 in dental benefits per individual per calendar year. The dollar maximum does not apply to pediatric dental care for Dependent children up to age 19.

Orthodontic care has a separate lifetime maximum benefit of $2,500 per individual. Orthodontic benefits are available only for your Dependent children under age 26.

Covered Services

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

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

Diagnostic and Preventive Services

- Diagnostic care—procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment, including the following:
    - Oral examination
    - Bitewing X-rays (2 times per calendar year)
    - Full mouth X-rays (during any period of 3 consecutive years)
    - Emergency palliative treatment
    - Specialist consultation
- Preventive care:
    - Cleanings (2 treatments per calendar year)
    - Fluoride treatment (2 treatments per calendar year) for Dependent children to age 14
    - Application of sealants (limited to one per tooth per year) for Dependent children to age 14 (covered for molar teeth only)

Basic Services and Restorations

- X-rays (other than bitewing X-rays), study models, space maintainers
- Restorative—amalgam, resin and composite restorations (fillings) for treatment of carious lesions (The allowance for amalgam restorations will be substituted for composite restorations posterior to the second bicuspid). Dental restoration 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 (precert is required).
- Endodontics—treatment of the tooth pulp, including necessary X-rays
- Periodontics—treatment of gums and bones supporting teeth
- Oral surgery—extractions and certain other surgical procedures, including pre- and post-operative care.

- Single Standing Crowns and other restorative services (replacement is covered only once every five years)

Major Services

- Fixed Bridges, Partial or Complete Dentures, Dental Implants
- Procedures for construction or repair of fixed bridges or partial or complete dentures
- Relines and rebases, including all lab or chair side treatment
- Dental implants: Benefits for an implant will be available up to the cost of a bridge or denture, and will be subject to the maximum calendar year benefit of $2,500 applicable to all participants older than 19 years.

Benefits will not be payable for the replacement of an existing prosthodontic appliance unless the existing appliance is at least four years old and cannot be made serviceable or the replacement is made necessary by the initial placement of an opposing full denture.

Orthodontic Services

The Fund provides all-inclusive orthodontic care benefits for eligible Dependent children to age 26. The Fund pays 100% of expenses (other than those specifically excluded immediately below), up to the lifetime maximum benefit of $2,500 per individual.

Orthodontic care benefits will not be paid for the following:

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

Exclusions from Coverage

Dental benefits will not be paid for the following:

- The replacement of a lost, misplaced, or stolen appliance before the normal prosthodontic period has passed
- CT Cone Beam
- Dental treatment involving the use of more costly materials (for example, gold) if such treatment could have been rendered at a lower cost by means of a reasonable substitute
- Expense incurred as a result of broken appointments
- Dietary planning, oral hygiene instruction, or training in preventive dental care
- Services in connection with preparation of a prosthetic appliance, including a crown or bridge, or any other dental expense incurred before you and your Dependents became eligible for coverage, including diagnostic work prior to treatment
- Prosthodontic services or any single procedure started before you and your Dependents became eligible for such services under this Plan, for example, teeth extracted prior to the date you were eligible for coverage, unless the denture or fixed bridgework also includes replacement of a natural tooth that is extracted while you are covered and the appliance is not an abutment to a partial denture or fixed bridgework installed within the preceding 4 years

- Prosthodontic appliances, crowns, or bridges that were ordered while you or a covered Dependent were eligible but are not installed or delivered until more than 60 days after termination of eligibility
- Any bodily injury or illness for which you or a covered Dependent is not under the care of a dentist
- Expenses in connection with occupational injuries or illnesses
- Services performed by the Spouse, child, brother, sister, or parent of the patient
- Any services or procedures that are experimental in nature or are not within the standards of generally accepted dental practice
- Services for congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth)
- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to the teeth's being out of alignment or occlusion, or for stabilizing the teeth and related procedures, including but not limited to equilibration and periodontal splinting
- Prescribed drugs, premedication, or analgesia when not included in the charge for covered dental services
- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services OR for children under the age 6 at an outpatient surgery center that has been pre-approved
- Any services or treatments excluded under "Covered Services" above
- Any services or treatments excluded under "General Exclusions, Limits, and Reductions" in Chapter 12
- Implants (materials implanted into or on bone or soft tissue) or the removal of implants unless the requirements of the Plan have been satisfied
- Full mouth debridement
- Treatment of TMJ (benefits may be available under the Medical Plan)

How to File a Claim For Dental Benefits

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

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

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, your dentist may use a standard claim form.*)
- Complete your portion of the form.
- Have the dentist's office complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
  - ✓ Your (the Employee's) name and Social Security number
  - ✓ Patient's name and address
  - ✓ Patient's birth date and relationship to you
  - ✓ Name, address, and tax ID number of the dentist providing services

- ✓ The codes for the dental procedures performed
- ✓ Date each service was performed and cost for each service
- ✓ The billing name and address

- Mail your claim form with your itemized bills to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.
- Mail any further bills or statements for any services covered by the Plan to the Northern Nevada Operating Engineers Health and Welfare Trust Fund as soon as you receive them.

NOTE: You must submit your claim **within 90 days** from the date on which Covered Expenses were incurred, unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than 1 year after the date on which Covered Expenses were incurred.

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 12, "Other Important Plan Information."

Chapter 6: Vision Care Benefits

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In this chapter you'll find:

- A quick-reference guide to vision care benefits
- How the Plan works
- Covered services and materials
- Exclusions from coverage
- Information on filing claims

Vision Plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. Employees may elect/decline Vision Plan benefits annually. Even though the Fund is not required to do so, it has extended vision coverage for Dependents up to age 26.

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

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

Vision Care Benefits *All benefits shown are available once per calendar year.*	
General Plan Features	
Maximum benefit	No lifetime or overall calendar-year maximum
Calendar-year deductible	None

Reimbursement Allowances for Covered Services and Materials **Dollar maximums in the schedule will not apply for pediatric vision services (which includes exams, frames, lenses and contacts) for eligible Dependents under the age of 19.**			
Item	**PPO Provider**	**Reimbursement Allowance for Non-PPO Provider**	**Reimbursement Allowance for Non-PPO Provider if you reside in Humboldt, Pershing, White Pine, Elko, Eureka, or Lander County**
Exam	100% of the PPO Contracted Rate	up to $40	up to $50
Frames	100% of the PPO Contracted Rate on select frames	up to $35	up to $43.75

Reimbursement Allowances for Covered Services and Materials **Dollar maximums in the schedule will not apply for pediatric vision services (which includes exams, frames, lenses and contacts) for eligible Dependents under the age of 19.**			
Eyeglass lenses:			*(All reimbursements are per pair of lenses)*
• **Single vision**	100% of the PPO Contracted Rate	up to $36	up to $45
• **Bifocal**	100% of the PPO Contracted Rate	up to $55	up to $68.75
• **Trifocal**	100% of the PPO Contracted Rate	up to $70	up to $87.50
• **Lenticular**	100% of the PPO Contracted Rate	up to $150	up to $187.50 per lenses
Tints and coatings:			
• **Photogrey tint or UV coating (Employee only)**	up to $20	up to $20	up to $25
• **Tint, Rose #1 or #2 (Dependents)**	up to $7	up to $7	up to $8.75
Contact lenses (instead of glasses):			
• **Medically necessary**	up to $225 per pair	up to $225 per pair	up to $281.25 per pair
• **For cosmetic purposes**	up to $96 per pair	up to $96 per pair	up to $120 per pair

How the Plan Works

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

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

Covered Services and Materials

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

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

- Following cataract surgery,
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses,
- In cases of anisometropia (a difference in the refractive power of the two eyes), or
- In cases of keratoconus (conical protrusion of the cornea).

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

Exclusions from Coverage

The Fund will not pay benefits for the following:

- Replacement of lenses and frames that are lost or broken (except at the normal intervals when services are otherwise available)
- Orthoptic or vision training, non-prescription lenses, glasses secured when replacement is not deemed medically necessary, or a second pair of glasses in lieu of bifocals
- Non-prescription sunglasses
- Medical or surgical treatment of the eyes (other than specifically listed as a covered service)
- Services or materials provided as a result of any Workers' Compensation law or similar legislation or services that can be obtained without cost from any Federal, state, county, or local organization or agency
- Any eye examination or glasses required by an employer or any service or materials provided by any other vision care plan or group benefit plan containing benefits for vision care
- Any services or treatments excluded under "General Exclusions, Limits, and Reductions" in Chapter 12

How to File a Claim For Vision Care Benefits

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

To file a claim for vision care benefits, follow these steps:

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, forms supplied by vision care providers are usually acceptable substitutes for claim processing.*)
- Complete your portion of the form.
- Have the vision care provider complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
  - ✓ Your (the Employee's) name and Social Security number
  - ✓ Patient's name and address
  - ✓ Patient's birth date and relationship to you
  - ✓ Name, address, and tax ID number of the optometrist, ophthalmologist, or optician providing services
  - ✓ Date each service was performed and cost for each service
  - ✓ The billing name and address

- Mail your claim form with your itemized bills to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.
- Mail any further bills or statements for any services covered by the Plan to the Northern Nevada Operating Engineers Health and Welfare Trust Fund as soon as you receive them.

NOTE: You must submit your claim **within 90 days** from the date on which Covered Expenses were incurred, unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than one year after the date on which Covered Expenses were incurred.

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 12, "Other Important Plan Information."

`Chapter 7: Weekly Disability Benefits

In this chapter you'll find:

- How the Plan works
- Injuries covered by Workers' Compensation
- Repeated instances of disability
- Exclusions from coverage
- Information on filing claims

Weekly Disability Benefits for Employees only	Help replace lost income when you are disabled, paying $200 per week for up to 26 weeks. Benefits begin the first day for a disability caused by an accidental injury or on the 8th day for a disability caused by illness.

How the Plan Works

The Fund will pay you a weekly benefit of $200 for up to 26 weeks if you become totally disabled and unable to work while you are eligible for benefits under this Plan.

Definition of "Totally Disabled"

For purposes of this benefit, "totally disabled" means:

a. A physician has certified in writing, for purposes other than making a benefit determination under the Fund, (i) that you are unable, due to Illness, Injury or pregnancy, to perform substantially all material duties of the occupation in which you are engaged, and (ii) the date on which you became Totally Disabled; and

b. That you are unable to engage in any gainful occupation.

Start and Duration of Benefits

If a physician's written certification is provided satisfying the requirements outlined above, weekly disability benefits begin as follows:

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

Benefits will continue until you are no longer disabled or you have reached the maximum of 26 weeks of continuous payments.

NOTE: Weekly disability benefits are subject to Federal income tax and Social Security/Medicare taxes.

Injuries Covered by Workers' Compensation

If your disability is the result of an occupational injury covered by Workers' Compensation Temporary Disability benefits, the Fund's weekly disability benefit will be reduced by any amount payable under the Workers' Compensation benefits.

Repeated Instances of Disability

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

- Due to unrelated causes as certified in writing by a physician; and/or
- Separated by a return to active full-time employment for at least two consecutive weeks.

Exclusions from Coverage

No benefits are payable:

- Unless a physician has made a written certification of Total Disability as required.
- For a disability that began before you became eligible for benefits under the Fund.
- Any bodily illness or injury for which evidence is not furnished to the Fund that you are totally disabled.
- Any disability suffered by your Spouse or Dependent children (weekly disability benefits cover Employees only).

No benefits are payable under the following circumstances:

- Once you are receiving permanent disability benefits ("Permanent disability" is defined as being certified as physically unable to engage in any employment for wages or profit for a period of at least 6 months).
- Once you are receiving Social Security benefits.
- Once you are receiving pension benefits.

How to File a Claim for Weekly Disability Benefits

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

- Obtain a Statement of Claim for Accident and Sickness Weekly Benefits from the Administrative Office.
- Complete the active Employee's portion of the claim form.
- Have your physician complete the attending physician's portion of the claim form.
- Check the claim form to be certain that all applicable portions of the form are completed. By doing so, you will speed the processing of your claim.
- Mail your claim form to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

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

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

NOTE: You must submit your claim **within 90 days** from the date of disability unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than one year after the date on which of disability.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in Chapter 12, "Other Important Plan Information."

Chapter 8: Employee Life Insurance

In this chapter you'll find

- How the Plan works
- Extended coverage for disability
- Conversion option
- Information on filing claims

Unlike the benefits discussed in the preceding chapters, which are paid directly by the Fund, Employee life insurance is provided through an insurance contract with the Life Insurance Carrier. This coverage is governed by the terms of that policy. A complete copy of your Life Insurance Plan is included at the end of this Summary Plan Description.

Employee Life Insurance	$10,000 coverage

How the Plan Works

This Plan pays a $10,000 benefit to your designated beneficiary in the event of your death—on the job or off—from any cause while you are insured under the Plan.

Payment of the Benefit

The $10,000 benefit will be paid to your beneficiary as you have filed with the Administrative Office.

Your Beneficiary

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

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

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

- Your Spouse,
- Your natural and adopted children, in equal shares,
- Your parents, in equal shares, or
- Your estate, in equal shares.

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

If your beneficiary is a minor or, in the opinion of the insurance company, legally incapable of giving valid receipt for any payment due him, the insurance company may make payment in monthly installments rather than in one sum.

Extended Coverage for Disability

ING will provide extended life insurance benefits if you become totally disabled while you are under age 60 and while you are covered by this Employee life insurance. For purposes of this extended benefit, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

The amount of coverage will be the same as the amount you had when you became totally disabled. This coverage will terminate when you are no longer totally disabled or you attain age 65.

If you die while disabled and your disability has been continuous from the time it started, the life insurance benefit will be paid to your beneficiaries, unless you have converted it to an individual policy (see below).

Written proof of total disability must be submitted to ING after you have been disabled for 3 months but within 12 months from the date you first became disabled. You will be required to submit evidence of your continuing total disability during each successive one-year period of your total disability.

Conversion Option

If You Cease to Be Eligible for Life Insurance

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

You may choose any type of individual contract being written by ING, except term insurance or insurance that provides disability or other supplementary benefits. The benefit amount of converted insurance may not exceed the benefit amount under this policy. The premium rate will be ING's customary rate for the form and amount of that policy for your age and class of risk.

Conversion Option Under Other Circumstances

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

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

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

- The benefit amount available on the date of termination, less any life insurance for which you are eligible or become eligible under any group policy within the conversion period or
- $5,000.

Applying for Conversion

If you wish to take advantage of the conversion option, contact the Administrative Office.

NOTE: If you die during the 31-day period allowed for conversion, ING will pay the life insurance benefit you could have converted to the last beneficiary you named, whether or not you have applied for conversion or paid the first premium.

How to File a Claim for Employee Life Insurance Benefits

Total Disability Extension

To file for an extension, follow these steps:

- Obtain a Disability Extension Application from the Administrative Office.
- Complete the active Employee's portion of the claim form.
- Have your physician complete the attending physician's portion of the claim form.
- Check the claim form to be certain that all applicable portions of the form are completed. By doing so, you will speed the processing of your claim.
- Mail your claim form to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

NOTE: you must file the application within 12 months from the start of your total disability. You must file proof of you continuing disability every 12 months. If you do not file the proof, your disability extension will end. You must also have an examination by a physician chosen by ING, if ING requires it. If you do not have the examination, your disability extension will end.

Death Claims

Your beneficiary should notify the Administrative Office as soon as possible after your death.

The Administrative Office will then send your beneficiary the forms necessary for filing proof of the loss and a claim for the benefit.

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

The claim form should be mailed to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

NOTE: If your coverage has been continued because of your total disability, written notice must be submitted within 12 months of your death.

If you or your beneficiary disagrees with the payment decision made in regard to the claim, a review of the decision can be requested. Please alert your beneficiary to the claims review information provided in Chapter 12 of this booklet.

Chapter 9: Life Insurance for Dependents

In this chapter you'll find:

- How the Plan works
- Conversion option
- Information on filing claims

Like Employee life insurance, life insurance for your eligible Dependents is provided through an insurance contract with the Life Insurance Carrier. A complete copy of your Life Insurance Plan is included at the end of this Summary Plan Description.

Dependent Life Insurance Benefits	
Death of your Spouse	$1,000
Death of your Dependent child	
• **Age 6 months through age 19 (age 23 for full-time students)**	$500
• **Age 14 days up to 6 months**	$100
• **Under 14 days**	No benefit

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

How the Plan Works

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

The amount of the benefit depends on whether the deceased was your Spouse or a child. If the deceased was a child, the amount further depends on the child's age. Benefit amounts are as shown in the chart above.

Conversion Option

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

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

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

Conversion Option Under Other Circumstances

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

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

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

- The benefit amount available on the date of termination, less any life insurance for which the Dependent is eligible or becomes eligible under any group policy within the conversion period or
- $5,000.

Applying for Conversion

If a Dependent wishes to take advantage of the conversion option, the Dependent can contact the Administrative Office.

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

How to File a Claim for Dependent Life Insurance Benefits

You should notify the Administrative Office as soon as possible after your Dependent's death. The Administrative Office will then send you the forms necessary for filing proof of the loss and a claim for the benefit.

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

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

If you disagree with the payment decision made in regard to the claim, a review of the decision can be requested. See the claims review information provided in Chapter 12 of this booklet.

Chapter 10: Employee Accidental Death and Dismemberment (AD&D) Insurance

In this chapter you'll find:

- How the Plan works
- Exclusions from coverage
- Information on filing claims

Like Employee and Dependent life insurance, Employee AD&D insurance is provided through an insurance contract with the insurance carrier. AD&D coverage is not provided for Dependents. A complete copy of your Life Insurance Plan is included at the end of this Summary Plan Description.

Schedule of Employee AD&D Benefits	
Description of Loss	**Benefit Payable**
Your death	$5,000
Loss of both hands or both feet	$5,000
Loss of sight in both eyes	$5,000
Loss of one hand and one foot	$5,000
Loss of one hand (or one foot) and sight in one eye	$5,000
Speech and hearing in both ears	$5,000
Loss of one hand or one foot	$2,500
Loss of sight in one eye	$2,500
Speech	$1,250
Hearing in both ears	$1,250
Loss of one thumb and index finger of the same hand	$1,250
Loss of a hand or foot means the complete and permanent severance of the entire hand or foot at or above the wrist or ankle joint. Loss of sight in an eye means the entire and permanent loss of the sight of that eye.	

How the Plan Works

The Plan insures you for up to $5,000 against death or dismemberment in an accident. The amount payable depends on the nature of the loss, as shown in the chart above.

The loss must be the direct result of a bodily injury suffered in a covered accident (on or off the job) and must occur at the time of the accident or within 90 days of the accident, independently of all other causes. The injury causing the loss must be sustained while you are insured under the Plan. If you suffer more than one loss in a single accident, the maximum combined benefit for all losses will be $5,000.

If the loss is your death, the $5,000 benefit will be paid to your beneficiary. You will find more information about beneficiaries in Chapter 8, "Employee Life Insurance." This is in addition to the $10,000 Employee life insurance benefit.

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

Exclusions from Coverage

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

- Suicide or intentionally self-inflicted injury, while sane or insane
- Physical or mental illness
- Bacterial infection or bacterial poisoning (Exception: Infection from a cut or wound caused by an accident)
- Riding in or descending from an aircraft as a pilot or crew member
- Any armed conflict, whether declared as war or not, involving any country or government
- Injury suffered while in the military service for any country or government
- Injury which occurs when you commit or attempt to commit a felony
- Use of any drug, narcotic or hallucinogenic agent

  - Unless prescribed by a doctor

  - Which is illegal

  - Not taken as directed by a doctor or the manufacturer
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

How to File a Claim for AD&D benefits

Death Claims

Your beneficiary should notify the Administrative Office as soon as possible after your death.

The Administrative Office will then send your beneficiary the forms necessary for filing proof of the loss.

Your beneficiary should complete the claim form and attach a certified copy of the death certificate. An autopsy report may be required.

The claim form should be mailed to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

If your beneficiary disagrees with the payment decision made in regard to the claim, a review of the decision can be requested. Please alert your beneficiary to the claims review information provided in Chapter 12 of this booklet.

Your beneficiary must file a claim for benefits **within 90 days** of the loss. (More time may be allowed if you cannot reasonably file the claim and proof of loss within this time.) In any case, the claim must be filed within one year of the date of the loss.

Dismemberment and Loss of Sight Claims

Notify the Administrative Office as soon as possible if you suffer one of the losses due to an accident.

The Administrative Office will then send you the form necessary for filing proof of the loss.

Complete the claim form. Have you physician complete the physician’s portion of the form.

The claim form should be mailed to:

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

If you disagree with the payment decision made in regard to the claim, a review of the decision can be requested. Refer to the claims review information provided in Chapter 12 of this booklet.

Your beneficiary must file a claim for benefits **within 90 days** of the loss. (More time may be allowed if your beneficiary cannot reasonably file the claim and proof of loss within this time.) In any case, the claim must be filed within one year of the date of the loss.

Chapter 11: Employee Burial Expense Benefit

In this chapter you'll find:

- How the Plan works
- Information on filing claims

The Employee burial expense benefit is provided through an insurance contract with Union Labor Life Insurance Company.

Burial Expense Benefit	$2,500

How the Plan Works

The Plan pays a burial expense benefit in the amount of $2,500 in the event of your death from any cause—on the job or off—while you are insured for this benefit.

The burial expense benefit will be paid to your beneficiary. This benefit is payable in addition to the $10,000 Employee life insurance benefit and, if death is caused by an accident, the $5,000 benefit payable under Employee accidental death and dismemberment benefit.

You may name anyone as the designated beneficiary, and you may change the designation at any time by filling out the proper form. To designate or change your beneficiary, complete a new beneficiary designation form (available from the Administrative Office) and send it to the Administrative Office.

If you have not designated a beneficiary or your beneficiary predeceases you, payment will be made to the first of the following that survives you: your lawful Spouse, your children, your parents, or your brothers and sisters. If none of these survives you, the benefit will be paid to your executor or administrator.

NOTE: If you are not eligible for the burial expense benefit under this Plan, the benefit may be provided for you through other contracts issued to the groups participating in the Operating Engineers Burial Expense Program. Your beneficiary should therefore contact the Union or the Administrative Office to ask about payment of this benefit in the case of your death.

How to File a Claim for the Burial Expense Benefit

Your beneficiary should contact your Local Union Office at (775) 857-4440, 1290 Corporate Blvd., Reno, NV 89502.

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims review information provided in Chapter 12 of this booklet.

Chapter 12: Other Important Plan Information

This chapter includes:

- Coordination of Benefits (COB)
- Qualified Medical Child Support Orders (QMCSOs)
- COBRA continuation of health care coverage
- Claims review procedures
- Factors that could affect your receipt of benefits
- General exclusions, limits, and reductions
- Your rights under ERISA
- General Plan information
- Plan facts

Coordination of Health Care Benefits

The health care benefits provided by the Fund are "coordinated" with any benefits under any other group plan or government plan that covers you or your Dependents. This Plan does not coordinate benefits with an individual plan. This means that when a plan participant is covered by an individual (non-group) plan/policy including a policy through the Health Insurance Marketplace, this Plan will not pay benefits toward claims that are covered by that individual plan/policy.

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

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

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

- **Employees:** A plan covering you as an active Employee is primary. A plan covering you as a laid-off or retired Employee is secondary, provided the secondary plan has this same rule. (This order will extend to any Dependent coverage you have under the plans, too.)

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

- **Spouses:** The plan covering the Spouse directly, as a nondependent rather than as an Employee's Dependent, is the primary plan. The plan covering the Spouse as a Dependent is the secondary plan.

- **Children:** If the parents **are *not* separated or divorced**, the primary plan is usually the plan of the parent whose birthday falls earlier in the calendar year. If the other plan does not have this "birthday rule," the rules in the other plan will determine the order of benefits.

If the parents ***are*** **separated or divorced** and two or more plans cover a child as a Dependent, benefit payments are first determined in accordance with any court decree. Otherwise, the plans pay benefits for the child in the following order:

- ✓ The plan of the parent with custody pays first,
- ✓ The plan of the stepparent—the Spouse of the parent with custody, if he or she has remarried—pays second, and
- ✓ The plan of the parent without custody pays last.

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

For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the plan that has covered someone for a longer period will pay first. If length of coverage is the same, then the Plan looks to whose birthday is earlier in the year: the Employee-parent covering the Dependent or the Employee-Spouse covering the Dependent.

Coordination with Prepaid Plans

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

Coordination with Medicaid

Payments by this Plan will be made in compliance with any assignment of rights as required by Nevada's plan for medical assistance approved under Title XIX, Section 1912(a)(1)(A) of the Social Security Act (Medicaid).

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

Coordination with Medicare

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

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

Age-Related Eligibility for Medicare

If you are an active Employee, your coverage under this Plan will not change when you reach age 65 or your Spouse reaches age 65. However, when you reach age 65, you have the option of choosing this Plan or Medicare as the primary health insurer for comprehensive medical benefits. Similarly, if your Spouse reaches age 65 before you do, he or she may independently choose Medicare as the primary health insurer.

If you or your Spouse chooses this Plan as primary, Medicare will assume secondary payer coverage; however, if you or your Spouse chooses Medicare as the primary insurer, this Plan will not provide any secondary payer coverage.

There is **one exception to the above rule** that this Plan is the primary payer for active Employees and their Dependents who are Medicare eligible due to age. The coverage under this Plan for Employees or their Dependents who become eligible for Medicare based on age will be secondary to Medicare only if the active Employee regularly works for a Signatory Employer who has fewer than 20 Employees on the payroll for each working day in each of 20 or more calendar weeks in the current calendar year and the preceding calendar year **AND** the Fund Office has applied to CMS for an exception and that exception has been approved by CMS.

End-Stage Renal Disease

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

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

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

Beginning with the 31st month, Medicare will become the primary payer. This rule applies regardless of whether the individual was eligible for Medicare based on age at the time they became eligible for Medicare based on ESRD.

The coverage under this Plan for any person who is eligible under the COBRA continuation provisions shall be secondary to coverage under any other group plan regardless of whether the group plan is as an active Employee or as a retiree or through Medicare. The sole exception is for the first 30 months of coverage due to ESRD, during which period the COBRA coverage will be primary payer.

Disability Cases

If you or a covered Dependent becomes entitled to Medicare based on a determination by the Social Security Administration that they are permanently disabled, Medicare will be the secondary payer while you continue to be eligible for benefits based on current active employment status.

When Covered by this Plan and the Individual also Enters Into a Medicare Private Contract

Under the law, a Medicare participant is entitled to enter into a Medicare private contract with certain providers (who have opted out of Medicare), under which the individual agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that provider. If a Medicare participant enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

When Covered by this Plan and also by a Medicare Part D Prescription Drug Plan

For Medicare eligible Active Employees and individuals no longer actively employed but still receiving benefits based on hours accumulated when they were working and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage is secondary.

Third-Party Payments (Subrogation)

The Fund shall be entitled to subrogation and / or reimbursement of all rights of recovery of a Participant,

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

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

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

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

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

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

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

The Fund may cease advancing benefits if there is a possible basis to determine this provision may not be enforceable, or if there is a basis to believe that Claimant will not honor the terms of this section. The Fund may also deny coverage for expenses incurred after recovery on the third-party claim, if such expenses are related to the third-party recovery. If the Fund is not reimbursed upon recovery on a claim, the Fund or its Trustees may bring an action against any Claimant to enforce the Fund's right to reimbursement and / or the

agreement to reimburse, and / or to seek a constructive trust or other remedy. In addition, without waiving any other remedy, the Fund may recoup the reimbursement by recovering from the source to which benefits were paid and / or by offsetting against future benefit payments that would otherwise be due to Claimant, the Participant of whom Claimant is a Dependent and any other Dependent of Claimant or such Participant.

Qualified Medical Child Support Orders (QMCSOs)

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and enrolls Dependent children as directed by such an Order. This Plan will also provide benefits in accordance with a National Medical Support Notice. In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. A Medical Child Support Order is any judgment, decree, or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law that:

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

To be qualified, a Medical Child Support Order must clearly specify

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

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

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

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

When a Qualified Medical Child Support Order Is Received

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

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

COBRA Continuation of Health Care Coverage

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

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

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov. Also, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense. **This Plan provides no greater COBRA rights than what is required by law and nothing in this chapter is intended to expand a person's COBRA rights.**

Qualifying Events

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

1. Employee terminates (for other than gross misconduct) including retirement.
2. Reduction of work hours or reduction to less than the minimum required (110) hours in your hour bank (hours previously banked plus hours reported by your Employer) making you ineligible for coverage
3. Your divorce or legal separation
4. Your death
5. The loss of status as an eligible Dependent child

Duration of COBRA Coverage

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

- **18 Months** - You and/or your Dependents can continue coverage for up to 18 months from the date of the Qualifying Event if you would otherwise lose coverage because less than the minimum work hours were reported for a month on your behalf (items 1 and 2).

- **29 Months** – An 18-month coverage period can be extended to a total of 29 months if you or your Dependent becomes disabled (as determined by the Social Security Administration) before or during the first 60 days of COBRA coverage. See "Extended COBRA Coverage in Cases of Disability."
- **36 Months** - Each of the other above-listed Qualifying Events (Items 3 through 5) entitles your Dependents to 36 months of coverage from the date of the Qualifying Event. In the case of a child's losing Dependent status, only the affected child is eligible for 36 months of coverage.

Can I enroll in Medicare instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because* you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Extended COBRA Coverage in Cases of Disability

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

- The disability occurred on or before the start of COBRA coverage or within the first 60 days of COBRA coverage.
- The disabled person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Employee, the disabled person or other family member notifies the Administrative Office that the determination was received. See "Your Duty to Notify the Administrative Office" below for notification deadlines.

The premium for the additional 11 months will be approximately 50% higher than the premium for the initial 18 months of COBRA coverage.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Extended COBRA Coverage If A Second Qualifying Event Occurs

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

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

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

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

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

Cost of Continuation Coverage – Benefits That May Be Continued

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

Paying for COBRA Coverage – Grace Period

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

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

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

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

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

If there is a significant shortfall then COBRA continuation coverage will end.

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

How to Obtain COBRA Continuation Coverage

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

Your Duty to Notify Administrative Office

You or your Dependents are responsible for providing the Administrative Office with timely notice of the following qualifying events:

- Your divorce from your Spouse (or have a legal separation),
- Loss of dependent status by a child, or
- The occurrence of a second qualifying event while your Dependents are in an 18-month COBRA continuation period (see "Extended COBRA Coverage If a Second Qualifying Event Occurs" above).

You must also provide the Administrative Office with timely notice when:

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

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

How to Notify the Administrative Office

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

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

If you have any questions about how to notify the Fund of one of these events, please call the Administrative Office at (775) 826-7200.

Where to Send Your Notice

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

Northern Nevada Operating Engineers Health and Welfare Trust Fund
445 Apple Street, Suite 109
PO Box 11337
Reno, NV 89510-1337

When to Notify the Administrative Office

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

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

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

Who Can Notify the Administrative Office

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

Electing Continuation Coverage

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

The Administrative Office will send you a notice if you have not met the eligibility requirements in a month. This notice will tell you when your eligibility will terminate and ask you to complete and return the form if you want self-pay for COBRA continuation coverage beyond the termination of your eligibility.

YOU MUST SIGN AND RETURN THE ELECTION FORM TO THE ADMINISTRATIVE OFFICE NO LATER THAN 60 DAYS AFTER THE DATE OF YOUR LOSS OF ELIGIBILITY OR THE DATE OF THE COBRA NOTICE FROM THE ADMINISTRATIVE OFFICE (WHICHEVER IS LATER) OR YOU WILL NOT BE ELIGIBLE FOR COBRA CONTINUATION COVERAGE. COBRA RIGHTS WILL BE FORFEITED IF YOU OR YOUR DEPENDENTS DO NOT FILE THE COBRA ELECTION FORMS WITHIN THIS 60-DAY PERIOD.

You do not have to show “proof of good health” to choose COBRA Continuation Coverage. If you do not choose continuation coverage, your health coverage will end. However, your Spouse and/or your eligible Dependents may elect continuation coverage, even if you do not.

Your initial continuation coverage will be identical to coverage provided to similarly situated Employees under the Plan on the day prior to the Qualifying Event, although it may be modified if coverage changes for other Employees or family members.

In considering whether to elect COBRA Continuation Coverage, you should take into account that a failure to continue your group health coverage may affect your future rights under Federal law:

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA Continuation Coverage if you pay for COBRA Continuation Coverage for the maximum time available to you.

Adding New Dependents

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

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

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

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

Termination of COBRA Continuation Coverage

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

However, if you are on military service, your Dependents may continue their coverage for an additional six months under the provisions of USERRA (to a maximum of 24 months). During this six-month extension, they will not be entitled to certain COBRA rights, such as the right to an additional 18 months of coverage if a second Qualifying Event occurs.

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

- You or your Dependents fail to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments);

- You or your Dependents become entitled to Medicare Part A or Part B after the date of your COBRA election;
- Your Employer no longer provides group health coverage to any of its Employees; or
- You or your Dependents have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your Dependents are no longer disabled.

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

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

Keeping the Administrative Office Notified

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

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

COBRA CONTINUATION COVERAGE CHART

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

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

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

Claims Review Procedures

Discussed below are the various types of claims associated with Plan benefits, procedures for filing claims, and the steps involved in appealing a decision with which you disagree. The processing times mentioned in the discussion are summarized in the charts at the end of the discussion.

Types of Claims

There are five types of claims applicable to the benefits described in this booklet. Three of them have to do with health care:

- **Urgent care claims:** A claim for medical care or treatment is an urgent care claim if you want approval of the benefit in advance and applying the time frames allowed by the Federal government for a regular pre-service claim (15 to 30 days for an initial determination) could seriously jeopardize your life or health or your ability to regain maximum function or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

  (NOTE: Your Plan does not have regular pre-service claims as defined by the Federal government because you are not required to get pre-authorization for any benefits.)

  The Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above, will be treated as an urgent care claim.

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

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

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

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

- **Other claims:** The category "other claims" includes claims for Employee and Dependent life insurance, Employee AD&D insurance, and Employee burial expense benefits.

What is NOT a "Claim"

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

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim

- A request for an advance determination regarding the Plan's coverage of a non-urgent medical treatment or service recommended by your physician *(Note, however, that getting such an advance determination does not guarantee payment of Plan benefits. For example, benefits would not be payable if your*

eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.)

- A prescription you present to a pharmacy to be filled (*However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section.*)

Filing a Claim

Information on how to file a claim is included in the chapter covering each type of benefit earlier in this booklet. As noted in those chapters, you can obtain a claim form from the Union or Administrative Office. You should submit your completed form with any required documentation to the Administrative Office at the following address (*see the box below for information on delivery of an urgent care claim*):

Northern Nevada Operating Engineers Health and Welfare Trust Fund
445 Apple Street, Suite 109
P.O. Box 11337
Reno, NV 89510-1337

Delivering an Urgent Care Claim

Do NOT submit a claim involving urgent health care via the U.S. Postal Service. Instead,

- FAX all urgent care claims except those for chemical dependency treatment to the attention of the Precertification representative at (775) 826-7289.
- For chemical dependency treatment, call in your urgent care claim to the Addiction Recovery Program (ARP) at (800) 562-3277.

Using an Authorized Representative

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

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

When Claims Must Be Filed

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

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

A request for a concurrent care decision to extend approved urgent care must be filed **at least 24 hours before the approved treatment expires**.

You must submit all other claims **within 90 days** of when expenses are incurred or a loss was experienced, unless you cannot reasonably submit the claim within that timeframe. Failure to file claims within that time will not invalidate or reduce any claim if it was not reasonably possible to file the claim within that time.

However, in such a case, you must submit the claim as soon as is reasonably possible and in no event later than 1 year after the date charges were incurred or the loss was experienced.

Timing of Initial Claims Decisions

The Administrative Office or the insurance company will make a determination on your claim within the following time frames:

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

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

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

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

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

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

- **Disability claims:** The Administrative Office will ordinarily make a decision on the claim and notify you of the decision within **45 days** of receipt of the claim. This period may be extended by up to **30 days** if the extension is necessary due to matters beyond the control of the Administrative Office. If an extension is necessary, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Administrative Office expects to make a decision. A decision will then be made within **30 days** of when the Administrative Office notifies you of the delay. The period for making a decision may be extended an additional **30 days**, provided the Administrative Office notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Administrative Office expects to render a decision.

  If an extension is needed because the Administrative Office needs additional information from you, the Administrative Office will notify you as soon as possible, but no later than **45 days** after receipt of the

claim, of the specific information necessary to complete the claim. You will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). Once you respond to the Administrative Office's request for the information, you will be notified of the Administrative Office's decision on the claim within **30 days**.

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

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

Denied Claims (Adverse Benefit Determinations)

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

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

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

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

Request for Review of an Adverse Benefit Determination

If you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Administrative Office as follows:

- Within **180 days** after you receive the notice of denial for a claim involving health care or disability (or, in the case of a concurrent care decision, within a reasonable time, given the medical exigencies of your situation)
- Within **60 days** after you receive the notice of denial for other claims

The Administrative Office may refer your appeal for life insurance or AD&D to the insurance company. You may appeal an adverse benefit determination regarding urgent care by faxing your request to the

Precertification representative at (775) 826-7289, calling the Administrative Office at (775) 826-7200, or going to the Administrative Office and asking to speak to the Precertification representative.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record, or other information is relevant if it was relied upon by the Administrative Office in making the decision; it was submitted, considered, or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

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

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

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

Notice of Decision on Appeal

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

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

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will include the following:

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

External Review of Certain Claims

This voluntary External Review process is intended to comply with the No Surprises Act external review requirements. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

The Plan is a grandfathered health plan and external review process requirements generally do not apply to coverage offered by grandfathered health plans. However, the federal external review process requirements under paragraph (d) of 45 CFR 147.136, and related notice requirements under paragraph (e) of 45 CFR 147.136 apply to certain adverse benefit determinations made by grandfathered plans. Paragraphs (d) and (e) of 45 CFR 147.136 apply to this Plan only with respect to adverse benefit determinations involving items and services within the scope of the requirements for Non-Contract Provider emergency services, non-emergency services performed by a Non-Contract provider at a Contract Facility, and air ambulance services furnished by Non-Contract providers of air ambulance services. Although the Plan is administered and domiciled in the state of Nevada, state standards for external review referenced in paragraph (c) of 45 CFR 147.136 are preempted because the Plan is a self-insured ERISA Plan, and the Plan has not opted into Nevada's external review law.

You may seek external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim results in an adverse benefit determination and is a claim for Non-Contract Provider Emergency Services, non-emergency services from a Non-Contract provider at a Contract facility, or Non-Contract air ambulance.

There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

Generally, you may only request external review after you have exhausted the Plan's internal claims and appeals process described above. This means that, generally, you may only seek external review after a final determination has been made on your appeal.

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

External Review of Standard (Non-Urgent) Claims

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.

1. 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:

   a. 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;

   b. 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.

   c. 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

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

2. 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:

   a. If your request is complete and eligible for external review; or

   b. 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)).

   c. 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.

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:

   a. 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).

b. 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.

c. 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.

d. 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).

e. 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).

f. 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.

External Review of Expedited Urgent Care Claims

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.

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).

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.

a. 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.

b. 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).

Discretionary Authority of the Board of Trustees

In carrying out their respective responsibilities under the Plan, the Board of Trustees have full discretionary authority to interpret the terms of the Plan, to resolve ambiguities and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Board of Trustees also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Facility of Payment

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

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review for every issue deemed relevant by you and until all administrative procedures have been exhausted and a final decision has been reached on review (or until the appropriate time frame described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision).

No lawsuit may be started more than 1 year after:

- The end of the year in which health care services were provided (for health care benefits),
- The start of the disability (for disability benefits),
- The date of death or other loss (for life and AD&D insurance or Employee burial expense benefits).

Factors That Could Affect Your Receipt of Benefits

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

- **Performance of work for a non-contributing employer or consent to under-contributing.** If you are under the hour bank system and you perform work covered by the Operating Engineers collective bargaining agreement for an employer that is not a contributing employer or you knowingly permit a contributing employer to contribute to the Fund for less than all of the hours you have worked, all remaining hours in your hour bank will immediately be canceled.
- **Failure to use covered providers for chemical dependency treatment.** The Plan's comprehensive major medical benefits require that you receive care from Addiction Recovery Program (ARP) providers if you want to receive benefits for chemical dependency treatment. See Chapter 3 for contact information.
- **Failure to submit claims in a timely way.** You must submit your claim **within 90 days** from the date on which Covered Expenses were incurred or a loss was experienced, unless it is not reasonably possible to submit a claim within that time limit. Benefits will not be allowed in any event if you submit your claim more than 1 year after the date on which Covered Expenses were incurred or the loss was experienced.
- **The Plan's provisions for coordination of health care benefits.** If you or a Dependent has health care coverage under another plan, payment of benefits by the Fund will be coordinated with payment of benefits by that other plan. See "Coordination of Benefits" earlier in this chapter for more information.
- **The Plan's subrogation provision.** You must reimburse the Fund for any benefits you receive for an illness or injury caused by a third party if you are compensated for that illness or injury by the third party or an insurer. See "Third Party Payments (Subrogation)" under "Other Important Plan Information". If the Fund sends you a letter asking for accident details and you don't respond, benefits may be denied.
- **Failure to update your address or enrollment card.** If you move, it is your responsibility to keep the Administrative Office informed about where it can reach you. Otherwise, you may not receive important information about your benefits. In addition, you must contact the Administrative Office regarding any changes in your family status. You will be held liable for benefit payments based on incorrect information about family members (for example, if you fail to notify the Administrative Office that you have divorced or a child has ceased to be an eligible Dependent). In addition, you may be liable for other costs incurred by the Fund as a result of the incorrect information. These costs include (but are not limited to) attorneys' fees, administrative costs, and reasonable interest.

Any factors affecting your receipt of benefits will depend on your particular situation. If you have questions, contact the Administrative Office at (775) 826-7200.

General Exclusions, Limits, and Reductions

The Fund will not provide benefits for the following:

- Any amount above the Allowed Charge in the applicable schedule of allowances or reasonable charges, whichever is less, or any services not considered customary and reasonable
- Services not specifically listed in the Plan's Rules and Regulations as Covered Expenses or services that are not medically necessary
- Services for which you are not legally obligated to pay or are not charged (or would not be charged, if you did not have insurance), except services received at a non-governmental charitable research hospital that meets all of the following criteria:
  - ✓ It is internationally known as being devoted mainly to medical research.

- ✓ At least ten percent of its yearly budget is spent on research not directly related to patient care.
- ✓ At least one-third of its gross income comes from donations or grants other than gifts or payments for patient care.
- ✓ It accepts patients who are unable to pay.
- ✓ Two-thirds of its patients have conditions directly related to the hospital's research.

- Work-related conditions if benefits are recovered or can be recovered under any workers' compensation, employer's liability, occupational disease, or similar law (If the right to recover such benefits is disputed, the Fund will provide benefits if you sign an agreement to prosecute a claim for such benefits diligently, consent to a lien by the Fund against your compensation for these benefits, and otherwise cooperate in securing reimbursement for the benefits provided.)
- Conditions caused by or arising out of an act of war, armed invasion or aggression; conditions caused by or arising out of involvement in the commission of a felony, self- inflicted injuries/suicide or drug abuse, unless the suicide attempt, self-inflicted injury (regardless of whether the Fund has a history of a previous mental health diagnosis), and/or the drug abuse arises as a result of a physical or mental health condition and except as discussed in Chapter 3 under "Mental Health" and "Chemical Dependency Treatment" in "Covered Services and Supplies"
- Except to the extent benefits are required by Federal law to be provided by the Fund, any services provided by a local, state, or Federal government agency, or any services for which payment may be obtained from any such agency (except Medicaid)
- Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision
- Expenses incurred by an eligible individual due to driving in or being in actual physical control of a vehicle while having 0.08% or more by weight of alcohol in his or her blood or driving while having an amount of a prohibited substance in blood or urine that exceeds the legal limit of the jurisdiction. This exclusion does not apply if the condition, injury or disability results from being the victim of domestic violence, or if the commission of the illegal act was a direct result of an underlying health factor.
- Any other expense specifically limited or excluded elsewhere in this booklet.

Your Rights Under ERISA

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate your plan, called ‘‘fiduciaries’’ of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration), U.S. Department of Labor, 200 Constitution Avenue, N. W., Washington, DC 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

General Plan Information

Assignment of Benefits

You may not sell, transfer, or otherwise dispose of benefits payable under the Plan or your right to receive Plan benefits, nor shall such benefits or rights be subject to the claims of creditors or other claimants. You may, however, direct that benefits be paid directly to a hospital or other health care provider instead of being paid to you.

Authority

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

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

See "Claims Review Procedures" earlier in this chapter for information on what to do if you disagree with the decision made in regard to a claim you have filed.

Right to Deductions from Future Benefits

If your benefits are overpaid or the Fund pays benefits for which you receive reimbursement elsewhere, the Fund may deduct the overpaid or reimbursed amounts from future benefits due you.

Right to Examinations

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

Right to Freedom from Liability for Payment

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

No Replacement for Workers' Compensation

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

Not a Contract of Employment

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

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

Plan Facts

Name of Plan	Northern Nevada Operating Engineers Health and Welfare Trust Fund
Type of Plan	Employee welfare benefit plan providing life insurance, accidental death and dismemberment insurance, burial expense, weekly disability income, comprehensive major medical, prescription drug, dental, and vision care benefits
Employee Identification Number (EID)	88-6031750
Type of Plan and Plan Number	Employee Welfare Benefits (501)
Funding Medium	All benefits are paid directly from Fund assets, except that ING Employee Benefits receives premiums to provide life insurance and accidental death and dismemberment benefits and The Union Labor Life Insurance Company receives premiums to provide a burial expense benefit.
Source of Contributions	The Fund is funded through employer contributions, the amount of which is determined by collective bargaining agreements. Some participants are allowed to contribute on their own behalf, as described in Chapter 2 of this SPD. Upon written request, the Administrative Office will provide any covered person or beneficiary information as to whether a particular employer is contributing to this Trust Fund and, if so, that contributing employer's address.
Plan Year	The date of the end of the Plan year is August 31.
Plan Sponsor/Plan Administrator	The Board of Trustees Northern Nevada Operating Engineers Health and Welfare Trust Fund 445 Apple Street, Suite 109 Reno, Nevada 89502 Telephone: (775) 826-7200 The Board is made up of trustees appointed by the participating employers and by the Union. Names and addresses of the Trustees as of the date this booklet was issued are shown below.
Agent for Service of Legal Process	Board of Trustees Northern Nevada Operating Engineers Health and Welfare Trust Fund c/o Benefit Plan Administrators, Inc. 445 Apple Street, Suite 109 Reno, Nevada 89502 Each member of the Board of Trustees is an agent for the purpose of accepting service of legal process on behalf of this Plan.

Administration of the Plan

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

Board of Trustees
Northern Nevada Operating Engineers Health and Welfare Trust Fund
c/o Benefit Plan Administrators, Inc.
445 Apple Street, Suite 109
Reno, Nevada 89510
Phone: (775) 826-7200

The administrative office is staffed with persons competent in the fields of accounting, data processing, and claims processing. The contract administration organization bills all participating employers monthly, receives the employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records of all reported Employees, and receives all claims filed by participating Employees. Please refer to the list of other organizations that administer claims on behalf of the Fund beginning on Page 93.

Trustees

The names and addresses of the Trustees as of the date of this booklet are listed below:

Employee Trustees

Steve Ingersoll, Co-Chairman
Operating Engineers Local 3
1620 So. Loop Rd
Alameda, CA 94502

Scott Fullerton
Operating Engineers Local 3
1290 Corporate Blvd.
Reno, NV 89502

Dave Harrison
Operating Engineers Local 3
1620 So. Loop Rd
Alameda, CA 94502

Alternate
Dylan Gallagher
Operating Engineers Local 3
1290 Corporate Blvd.
Reno, NV 89502

Alternate
Dan Reding
Operating Engineers Local 3
1620 So. Loop Rd
Alameda, CA 94502

Employer Trustees

Craig Madole, Co-Chairman
Nevada Chapter AGC
P.O. Box 7578
Reno, NV 89502

Kevin Linderman
Q And D Construction
P.O. Box 10865
Reno, Nv 89510-0865

Fred Reeder
TW Construction Company
P.O. Box 61900
Reno, NV 89510

Alternate
Chris Burke
Granite Construction
1900 Glendale Ave
Sparks, NV 89431

Funding Arrangements and Organizations Through Which Benefits Are Provided

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

Life insurance and accidental death and dismemberment coverage are insured and are provided under a contract with The Union Labor Life Insurance Company. The burial expense benefit is insured and is provided under a contract with The Union Labor Life Insurance Company. The complete terms of the benefits provided are set forth in the insurance policies or service agreements with these organizations.

Following are the names and addresses of the organizations through which benefits are provided or administered:

Benefit Plan Administrators, Inc.

Trust Fund Office
P.O. Box 11337
Reno, Nevada 89510-1337

(administers PPO Provider program and utilization management program)

OptumRx
P.O. Box 29077
Hot Springs, AR 71903

(administers the retail and mail order prescription drug program)

The Union Labor Life Insurance Company
1625 Eye Street, NW
Washington, D.C. 20001
(provides fully insured Life insurance, Accidental Death and Dismemberment and burial expense benefits)

Plan Documents

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the administrative office during regular business hours. Upon written request, copies of these documents will be provided. These documents are also available on the oe3health.org website.

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

Collective Bargaining Agreements

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

Upon written request, the Administrative Office will provide any covered person or beneficiary information as to whether a particular employer is contributing to this Trust Fund and, if so, that contributing employer's address.

Future of the Plan and Trust Fund

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

Plan Amendment or Termination

Although the Board currently intends to continue the Plan, it is under no legal obligation to do so. Accordingly, the Board reserves the right, solely at its discretion, to amend or terminate the Plan at any time.

This right includes, but is not limited to,

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

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

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

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

Chapter 13: Glossary of Terms Used in the SPD

Accident. (*For purposes of accidental death and dismemberment insurance*) An event that was caused by a sudden, violent, and external force; was not expected and could not have been reasonably foreseen; could not have been avoided; and caused a physical injury.

Addiction Recovery Program (ARP). The program that coordinates services for the treatment of substance abuse for Employees and Dependent Spouses.

Allied Health Practitioner means a practitioner of the healing arts (behavioral health practitioner, chiropractor, 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. Allied Health Professional shall include interns that are licensed through the State Board of the interns respective specialty.

Allowed Charge means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. For Non-Contract Provider Emergency Services, non-Emergency Services provided by Non-Contract Providers at Contract facilities, and Non-Contract Air Ambulance services, the Allowed Charge is the Recognized Amount or the Out-Of-Network Rate when a claim is resolved by settlement agreement or IDR. For all other services, the Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to a PPO provider**, the PPO Contracted Rate allowance; **or**
2. **With respect to a Non-Network provider**, Allowed Charge amount means the Non PPO Fee Schedule the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Contract providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. **or**
3. For a PPO facility whose network contract stipulates that they do not have to accept the network Contracted fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the contracted fee/rate that would have been payable by the Plan had the claim been processed as a PPO claim; **or**
4. The provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the provider's actual charge for services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

Any amount in excess of the "Allowed Charge" amount does not count toward the Plan's annual Out-of-Pocket maximum. Participants are responsible for amounts that exceed "Allowed Charge" amounts by this Plan.

Ancillary Services. The term "Ancillary services" means, with respect to a Contract health care facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
2. Items and services provided by assistant surgeons, hospitalists, and intensivists;
3. Diagnostic services, including radiology and laboratory services; and

4. Items and services provided by a Non-Contract provider if there is no Contract provider who can furnish such item or service at such facility.

Appropriate. A service or supply called for by the health status of a patient and likely to result in information that could affect the course of treatment (said of a diagnostic procedure) or produce a significant positive outcome (said of a care or treatment). In either case, the supply or service is considered no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

Brand-name drug. A prescription drug that is sold under a trademark name or created by the manufacturer who may hold a patent on the drug.

Coinsurance. The arrangement by which you and the Fund each pay a percentage of Covered Expenses.

Complications of Pregnancy. All physical effects suffered that have been directly caused by the pregnancy but that would not be considered from a medical viewpoint the effects of a normal pregnancy. These will include, but are not limited to, conditions such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy that terminated, cesarean section, spontaneous terminations of pregnancy that occur during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.

Copayment. The amount you pay toward the cost of prescription drugs under your prescription drug benefits.

Cost-efficient. A medical service or supply that is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

Cost Sharing. The term "Cost Sharing Amount" means the amount a participant or dependent is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Non-Contract providers, or the cost of items or services that are not covered under the plan.

The Cost Sharing Amount for Non-PPO Provider Emergency Services, Non-emergency Services at PPO Facilities performed by Non-PPO Providers, and air ambulance services from Non- PPO providers will be based on the Recognized Amount or the Out-Of-Network Rate when a claim is resolved by settlement agreement or IDR. Unless the Fund receives sufficient documentation showing the No Surprises Act does not apply to a billing for a covered item or service, that billing is not included in the Cost Sharing Amount. .

Continuing Care Patient: The term "Continuing Care Patient" means an individual who, with respect to a provider or facility-

- Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is or was determined to be terminally ill (as determined under section 186l(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Covered Expense. Charges that are made for the Medically Necessary care of and treatment of an Illness or Injury *that is covered under the Plan. The Covered Expense is the lowest of:

- Allowed Charges, as defined;
- The contracted rate for services of a Contract Hospital or Contract Provider;
- The Scheduled Allowance for services of a Non-Contract Hospital or Non-Contract Provider; or
- The contract rate between the health care provider and a plan with which this Plan is coordinating benefits.

Dentist. A dentist licensed to practice dentistry in the state in which he renders treatment.

Dependent. See description beginning on page 17 in the Eligibility Chapter.

Drugs. Any article that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a physician or dentist licensed by law.

Emergency Medical Condition. The term "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

Emergency Services. The term "Emergency Services" means the following:

- An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
- Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-Contract provider or Non-Contract emergency facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

- The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or
- The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and
- The participant or dependent gives informed consent to continued treatment by the Non-Contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

Experimental. A medical, surgical, diagnostic, psychiatric, substance abuse, or other health care service, technology, supply, treatment, procedure, drug therapy, or device of which, in the opinion of the Plan

Administrator or its designee, ***any*** of the following was true regarding one or more essential provisions when it was provided or performed (based on the information and resources then available):

- The prescribed service or supply could be given only with the approval of an Institutional Review Board as defined by Federal law.
- A preponderance of authoritative medical or scientific literature written by experts in the field and published in the United States showed that recognized medical or scientific experts classified the service or supply as experimental and/or investigational or indicated that more research was required before the service or supply could be classified as equally or more effective than conventional therapies (or there was an absence of authoritative medical or scientific literature on the subject).

  Authoritative peer-reviewed medical or scientific writings that will be considered include the "United States Pharmacopeia Dispensing Information"; "American Hospital Formulary Service"; "American Medical Association (AMA) Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program" or similar publications of the AMA; specialty organizations recognized by the AMA; the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Agency for Health Care Policy and Research (AHCPR); other agency review organizations such as ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries; the American Dental Association (ADA), with respect to dental services or supplies; and the latest edition of "The Medicare Coverage Issues Manual."
- Food and Drug Administration (FDA) approval was required for the service and supply to be lawfully marketed and it had not been granted at the time the service or supply was prescribed or provided or a current investigational new drug or new device application had been submitted and filed with the FDA.

  (However, a drug will NOT be considered experimental and/or investigational if it has been approved by the FDA as an "investigational new drug for treatment use"; classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and prescribed for the treatment of a type of cancer for which it was not approved for general use, provided the FDA has not determined that such drug should not be prescribed for a given type of cancer.)
- The prescribed service or supply was available to the covered individual only through participation in Phase I or Phase II clinical trials or through Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

Fund. The Northern Nevada Operating Engineers Health and Welfare Trust Fund.

Generic drug. A prescription drug that is chemically the same (has the same active ingredients) as the brand-name drug and is usually referred to by its common chemical name. A generic drug can be produced and sold after the patent has expired on a brand-name drug.

Habilitative/Habilitation: Health care services, such as physical therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of habilitative services includes physician-prescribed therapy for a child who is not walking or talking at the expected age.

Healthcare Facility. The term "Health Care Facility" (for non-emergency services) means each of the following:

- A hospital (as defined in section 1861(e) of the Social Security Act);
- A hospital outpatient department;
- A critical access hospital (as defined in section 1861(mm)(l) of the Social Security Act);
- An ambulatory surgical center described in section 1833(i)(l)(A) of the Social Security Act; and
- Any other facility, specified by the Secretary, that provides items or services for which coverage is

provided under the plan or coverage, respectively.

Home health care agency. An agency that meets all of the following requirements:

- It provides skilled nursing services and other therapeutic services under the supervision of physicians and registered nurses.
- It operates according to rules established by a group of professional medical people, including physicians and registered nurses.
- It maintains clinical records on all patients.
- It is licensed by the jurisdiction where it is located and operates according to the laws of that jurisdiction that pertain to agencies providing home health care.

Hospice program. The term "hospice" means a health care facility or service providing medical care and support services, such as counseling, to terminally ill persons and their families.

The term "approved hospice program" means a hospice program which meets state as a hospice (in states with licensure requirements), and is a Medicare certified hospice or a Medicare demonstration hospice site, or is accredited by The Joint Commission (TJC).

Hospital. The term "Hospital" means any acute care hospital which is licensed under any applicable state statute and must provide:

- 24-hour inpatient care, and
- the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

A Hospital may include facilities for mental health and/or substance use disorder treatment that are licensed and operated according to state law. The requirement that a Hospital must provide surgical, anesthesia and/or radiology services does not apply to facilities for mental, nervous and/or substance abuse treatment.

Illness. A bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes. The term "Illness" shall also include pregnancy for a covered Employee or Spouse.

Independent Freestanding Emergency Department. The term "Independent Freestanding Emergency Department" means a healthcare facility (not limited to those described in the definition of health care facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

Injury. 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.

Investigational. See "experimental."

Licensed pharmacist. A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Local Union. Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Major Services: Major dental care refers to services that are more extensive than fillings or root canals. These types of services can include treatments such as fixed bridges, partial and complete dentures – services that replace damaged or missing teeth.

Medically necessary. A service or supply that is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it and is determined by the Plan Administrator or its designee to meet ***all*** of the following requirements:

- It is consistent with the symptoms or diagnosis and treatment of the illness or injury,
- It is not provided primarily for the convenience of the patient, physician, hospital or health care facility, or other health care provider,
- It is an "appropriate" service or supply (*see definition earlier in glossary*), given the patient's circumstances and condition,
- It is a **"**cost-efficient**"** supply or level of service (*see definition earlier in glossary*) that can be safely provided to the patient, and
- It is safe and effective for the illness or injury for which it is used.

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 medically necessary for the medical coverage provided by the Plan. A hospitalization or confinement to a skilled nursing facility or other specialized health care facility will NOT be considered medically necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated without the patient's being confined.

Medicare. The benefits provided under Title XVIII of the Social Security Amendments of 1965.

Non-Contract Emergency Facility. The term "Non-Contract emergency facility" means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship with Northern Nevada Operating Engineers Health and Welfare trust Fund, with respect to the furnishing of an item or service under the plan or coverage respectively.

Non-Contract Hospital. A hospital that does not have a contract in effect with the Fund under the Preferred Provider Organization (PPO).

Non-Contract provider. Any Physician or Allied Health Practitioner, laboratory or radiology facility, free-standing surgical facility or provider of durable medical equipment that does not have a contract in effect with the Fund under the Preferred Provider Organization (PPO). Non-Contract Provider shall also include an ophthalmologist, optometrist or optician with who does not have a contract in effect with the Fund with respect to services covered under the Vision Care Benefits. Contract Provider shall also include a Dentist who does not have a contract in effect with the Fund with respect to services covered under the Dental Benefits.

Non-PPO Scheduled Fee Schedule. See Allowed Charge.

No Surprises Act. The term "No Surprises Act" means the federal No Surprises Act (Public Law 116-260, Division BB).

Out-of-Network Rate. The term "Out-of-Network Rate" with respect to non-emergency items and services furnished by a Non-Contract provider at a Contract Facility, Non-Contract Provider emergency facility, or Non-Contract provider of air ambulance services, means one of the following:

- The amount the Fund and Non-Contract Provider agree upon, provided that, if the settled Claim is covered by the No Surprises Act the settlement does not result in higher participant or dependent Cost sharing than is permitted under the No Surprises Act.
- The amount the parties agree upon during the open negotiations period under the No Surprises Act;

- The amount of the offer selected by the independent dispute resolution (IDR) entity under the No Surprises Act; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system. The Fund is administered and domiciled in Nevada and Nevada does not have an All-Payer Model Agreement.

Patient. The eligible individual who is receiving healthcare treatment, services, or supplies covered by the Plan.

Physician. A physician (or Allied Health Practitioner) and surgeon (M.D.), an osteopath (D.O.), or a dentist (D.D.S. or D.M.D.), ophthalmologist, optometrist or optician licensed to practice medicine in the state in which he or she practices. Allied Health Professional shall include interns that are licensed through the State Board of the interns respective specialty.

Plan. The "Plan" means the Rules and Regulations of the Direct Payment Plan and any amendments to it.

PPO Contracted Rate. See Allowed Charge.

PPO Plan. A program whereby hospitals, laboratory/radiology facilities, and physicians and Allied Health Practitioners and other health care facilities contract with the Fund to provide necessary hospitalization and medical services to eligible individuals at a contracted rate, approved by the Board and amended from time to time.

PPO Service Area. The area within the State of Nevada where eligible individuals who live there are subject to the reimbursement provisions of the Preferred Provider Plan.

Qualifying Payment Amount. The term "Qualifying Payment Amount (QPA)" means the amount calculated using the methodology described in 29 CFR 2590.716-6(c).

Recognized Amount. The term "Recognized Amount" means (in order of priority) one of the following:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act. The Fund is administered and domiciled in Nevada and Nevada does not have an All-Payer Model Agreement;
- An amount determined by a specified state law. The Fund is administered and domiciled in Nevada and Nevada law is pre-empted because the Fund is self-insured and has not opted into being administered under Nevada law; or
- The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

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 (QPA).

Reciprocity Agreement. The agreement that establishes the administrative procedures for reciprocity between the funds signatory Operating Engineers Health and Welfare Reciprocity Agreement and any modification, amendment, extension, or renewal thereof.

Retired Employee. A person receiving a pension from the Pension Trust Fund for Operating Engineers. A person who continues to be an Employee after reaching age 70-1/2 and is receiving a pension as required by Section 401(a)(9)(c) of the Internal Revenue Code shall not be considered a retired Employee until such time as he no longer meets the eligibility requirements discussed in Chapter 2 of this booklet.

Serious and Complex Condition. The term "Serious and Complex Condition" means with respect to a participant, dependent, or enrollee under the Plan one of the following:

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

Spouse: An Employee's Spouse means a person of the **opposite gender or same gender** who is legally married under State law. The Plan follows the IRS guidance that a same gender couple is married for federal tax purposes if the couple was married in a state that allows same gender marriage, regardless of the laws of the state in which the married couple resides or the foreign jurisdiction in which the individuals' marriage was entered into. The Plan will require proof of the legal marital relationship. The following are not defined as a Spouse under this Plan: a legally separated Spouse (when legal separation is permitted by state law), a domestic partner, a civil union, or a divorced former Spouse of an Employee, a common law marriage, or a Spouse of a Dependent Child.

Termination. The term "Termination" includes, in the context of Continuity of Care, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Totally disabled. Unable, due to illness, disease, injury, or pregnancy, to perform substantially all of the material duties of the occupation in which you were engaged prior to disability and not engaged in any gainful occupation. For purposes of extended Employee life insurance coverage, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

Trust Agreement. The Trust Agreement establishing the Northern Nevada Operating Engineers Health and Welfare Trust Fund and any modification, amendment, extension, or renewal thereof.