

# **U.A. LOCAL 350 RETIREE HEALTH AND WELFARE PLAN**

**(SUMMARY PLAN DESCRIPTION  
AND  
PLAN DOCUMENT)**

September 2014



***Nevada Association  
of Mechanical Contractors***



***(Medical, Hospital, and Prescription Drug Benefits for  
Retirees and Dependent Spouse)***

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# U.A. LOCAL 350 RETIREE HEALTH AND WELFARE PLAN

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Dear Retiree:

The Board of Trustees is pleased to provide you with this Summary Plan Description (SPD) that is also the Plan document for the U.A. Local 350 Retiree Health and Welfare Plan. The first part of the booklet contains general information regarding your medical and related benefits and an explanation of the eligibility provisions for Retired Participants who have exhausted COBRA continuation coverage under the U.A. Local 350 Active Health and Welfare Plan or have chosen continued coverage under this Retiree Health Plan as an alternative to COBRA continuation coverage, and their eligible Spouses. **There is no Dependent Children coverage under the Retiree Plan.** We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Plan Office at the above address. The benefits described in the booklet are effective September 1, 2014.

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

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

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

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

Sincerely,

Board of Trustees

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## **IMPORTANT NOTICES**

### **CAUTION – FUTURE PLAN AMENDMENTS**

Future amendments to the Plan may be made from time to time to comply with new laws passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. You will be notified in writing if there are important amendments to the Plan. Before you decide to retire, you may want to contact the Plan Office to determine if there have been Plan amendments or other developments that may affect your retirement Plans. This Plan provides only limited retiree medical benefits in any event.

### **LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT**

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

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

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

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

### **NO VESTED RIGHTS**

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

## **INTRODUCTION**

This booklet contains the Summary Plan Description (“SPD”) and the formal Health and Welfare Plan Document as of September 1, 2014. The first part of the booklet is the SPD portion of the Health and Welfare Plan. It starts with a short summary and schedules of the Plan’s key provisions. The SPD is followed by the formal Eligibility Rules and Benefit Rules beginning on page 12. (Definitions are in Article V.)

## **SUMMARY PLAN DESCRIPTION**

### **I. IMPORTANT INFORMATION**

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

1. Appropriate and necessary for the symptoms, diagnosis or treatment of an illness, injury or condition; and
2. Not experimental, educational or investigation; and
3. Not primarily for your convenience or the convenience of your physician or other provider; and
4. Within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in Nevada; and
5. The most appropriate supply or level of service which can safely be provided; and
6. When applied to hospitalization, the symptoms or condition cannot safely and adequately be treated on an outpatient basis; and
7. The fact that a physician or other medical provider may prescribe, order, recommend or approve a service does not of itself make such a service or supply Medically Necessary, even though it is not specifically listed as an exclusion.

**B. CONTRACT FEE SCHEDULE.** The Rules and Regulations utilize a Contract Fee Schedule or Non PPO Fee Schedule only. Thus, the Plan does not use “Usual Customary and Reasonable”, “Reasonable and Customary” or “Billed Charges”.

**C. SPECIFIC EXCLUSIONS.** The Plan lists several types of medical procedures, supplies and other charges which are **not** covered by the Plan. The specific exclusions are listed on pages 25-28 of this booklet. Exclusions for your Prescription Drug Coverage are listed on Pages 34-25.

**D. MEDICARE COORDINATION—YOU ARE REQUIRED TO ENROLL.** Medicare is our country’s federal health insurance program for people age 65 or older, with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. **If you or your Spouse are eligible for Medicare, you should carefully read this section. It will tell you what your obligations are concerning enrolling in Medicare Part A and B, how the Plan pays when you are eligible for Medicare, and other important information you need to know.**

**Medicare has four parts:**



- **Medicare Part A** – Hospital Insurance. Generally, there is no monthly premium, but there are annual deductibles and co-insurance/co-payments after certain lengths of stay.
- **Medicare Part B** – Medical Insurance. Part B requires payment of a monthly premium, as well as deductibles and co-insurance/co-payments. You should enroll in Part B when first eligible to avoid a financial penalty and a potential delay in your enrollment.
- **Medicare Part C** – Medicare Advantage Plans. Health plan options approved by Medicare and administered by private companies.
- **Medicare Part D** – Prescription Drug Coverage. Provided through plans run by insurance companies or other private companies approved by Medicare. There are monthly premiums, deductibles and co-insurance/co-payments.

Medicare Part A is financed by payroll taxes, and if you are eligible to receive it based on your own-or your spouse's-employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage.

The Plan supplements and coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). **This means that if you are retired you must enroll in both Medicare Part A and Part B, as soon as you are eligible for Medicare.** If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium.

**IMPORTANT NOTICE: ENROLL IN MEDICARE**

**To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent Spouse are required to formally enroll in both Medicare Parts A and B and pay the required premium as soon as you and/or your eligible Dependent(s) are entitled to coverage.**

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. The cost of Medicare Part B premium will go up 10% for each full 12-month period an individual was eligible for Medicare Part B during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll.

For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at [www.medicare.gov](http://www.medicare.gov).

**EXAMPLE:** Below is an example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.

*Assume Bob, a Medicare-eligible Retiree, requires a medical services and most physicians charge \$150.00 for it. Assume that Medicare's allowed amount for the services is \$100.00, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% co-insurance. If Bob is enrolled in Medicare Part B, and has satisfied the Part B deductible, the Plan would pay \$20.00 because Medicare would have paid \$80.00, and the claim would be considered paid in full. However, if Bob is eligible for but not enrolled in Medicare Part B, then the Plan will still pay \$20.00 and Medicare will pay nothing. Consequently, Bob is responsible for \$130.00 (\$150.00 minus \$20.00 paid by the Plan).*

To avoid loss of protection, you (or your Dependent Spouse) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependent Spouse) will become eligible for Medicare. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. **Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B.**

**E. Fund Office Needs Your Current Address.** When the Fund Office is informed that your or a dependent spouse's coverage is going to terminate, it is required by law to send you information about your right to make self-payments. Therefore, you should always provide the Fund Office with the current mailing address for you and your eligible dependent spouse so that this information as well as other important notices can be provided to you.

**F. Pronouns Used in this Booklet.** Wherever the term "you" or "your" is used in this booklet, it means an eligible retiree. And, to avoid awkward wording, male personal pronouns are used to refer to employees and retirees. Feminine pronouns are used when referring to spouses. When a personal pronoun is used in the masculine gender, it shall be deemed to include the female also, unless the context clearly indicates the contrary. Similarly, feminine pronouns will include the masculine.

## **II. SCHEDULE OF RETIREE MEDICAL BENEFITS**

### **BASIC MEDICAL BENEFITS**

*Self Funded Benefits Provided by the Fund*

<b>Outpatient Emergency Accident Benefit –</b> For Hospital only, treatment provided within 24 hours	\$100 per Period of Disability, then Major Medical Benefits apply
<b>Outpatient Surgery Facilities Benefit</b>	\$100 per Surgical Procedure, then Major Benefits apply
<b>Voluntary Second Surgical Opinion –</b> Prior to an elective non-Emergency Surgical Procedure	\$100 per Surgical Option
<b>Preadmission Testing Benefit</b>	Payable within 7 days of Hospital Admission
<b>Ambulance Service Benefit</b>	\$25 per Period of Disability, then Major Medical Benefits apply
<b>Additional Accident Care Benefit</b>	\$300 per Accident, then Major Medical Benefits apply
<b>Hospice Care Benefit</b>	\$5,000 Maximum Benefit
<b>Retiree Lifetime Maximum</b>	<b>\$5,000</b> per retired Participant and <b>additional \$5,000</b> for retired Participant's Spouse. A \$100 deductible will apply to the Participant or Spouse if they are not eligible for Medicare.

Please also refer to ***EXCLUSION AND GENERAL LIMITATIONS*** beginning on page 25 and Plan rules on ***SUBROGATION (third party recovery)*** and ***COORDINATION OF BENEFITS*** on pages 37- 38 and 40-44.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
<b>(1) Annual Deductible</b> (Applies to all expenses unless noted) <b>Note: Does not include coinsurance</b>	<b>MEDICAL DEDUCTIBLE AMOUNT</b>	
	<b>Per Person:</b> You pay \$100 per person per calendar year (if not eligible for Medicare). There is no deductible if you are eligible for Medicare.	
<b>(2) Lifetime Maximum</b>	<b>Major Medical Benefits</b> For Retirees, there is a <b>\$5,000</b> lifetime maximum benefit. There is an <b>additional \$5,000</b> lifetime maximum benefit for Retiree Spouse. All medical benefits paid by the Plan are applied to the Lifetime Maximum. Any medical expenses incurred after this maximum has been reached will be your responsibility.	
<b>(3) Percentage Payable</b>	For Covered Expenses, the percentage payable will be at 100%, depending on the particular Preferred Provider or Non-Preferred Provider that is utilized. <b><i>The use of Preferred Providers will reduce your out-of-pocket expense.</i></b>	
<b>Coinsurance Limit</b>	The Non-Preferred provider rate in the Reno or outside Reno/Sparks area is 100% of the Schedule Allowance.	
<b>Hospital Services</b>	<i>Non-Preferred Provider Outside Reno/Sparks Area</i>	<i>Preferred Provider</i>
<b>Inpatient Hospital Expenses</b>	Percentage of Scheduled Allowance 100%	Percentage of discounted fees 100%
		<i>Non-Preferred Provider within Reno/Sparks Area</i> Percentage of Scheduled Allowance 100%
	Any elective, non-emergency Hospital confinement is subject to Hospital Precertification. BEFORE you or your Dependent are admitted to a Hospital, you need to receive certification from the Professional Review Organization.	
BENEFIT	THE PLAN PAYS	THE PLAN PAYS
<b>(4) Hospital Benefits</b>	(Calendar Year Deductible Applies)	
• <b>Inpatient Services</b>	100%	100% of Allowance, patient pays the excess.
• Extras	100%, except payment not to exceed \$50 for physiotherapy in a convalescent hospital during a continuous period of disability.	"
• Emergency Room (urgent care)	\$25 charge per emergency room and/or urgent care visit	"
• <b>Outpatient Services</b>	100% of Allowance.	"
<b>(5) Ambulance</b>	(Calendar Year Deductible Applies)	
• Maximum	100% for a surface ambulance. Air ambulance subject to medical review.	Same
<b>(6) Physician Services</b>	(Calendar Year Deductible Applies)	
• Office Visits	100% of Discounted fees	100% of Schedule Allowance, patient pays the excess.
• Anesthesia	100% of Discounted fees	100% of Network Allowance, patient pays excess + co-pay.
• Hospital Visits	100% of Discounted fees	100% of Schedule Allowance, patient pays the excess.
• Surgical Care	100% of Discounted fees	100% of Schedule Allowance, patient pays the excess.
• Musculoskeletal Manipulation Limited to 25 visits per calendar year	100%	100%
• Diagnostic Laboratory	100%	100%
• Prosthetic Devices and Medical	100%	100%

Equipment • Physical Therapy: 30 per visits per calendar year	100%	100%
• Skilled Nursing	100%	100%
	<b>NETWORK PROVIDERS</b>	<b>NON-NETWORK PROVIDERS</b>
<b>BENEFIT</b>	<b>THE PLAN PAYS</b>	<b>THE PLAN PAYS</b>
<b>(7) Diagnostic Coverage</b> (Calendar Year Deductible Applies)		
• X-ray Procedures	100% of Allowance.	100% - patient pays excess over Allowance.
• Laboratory Procedures	100% of Allowance.	100% - patient pays excess over Allowance.
<b>(8) Mental Health Care</b> (Calendar Year Deductible Applies)		
• Inpatient	100% of Allowance. Same basis as benefit provided for any other illness.	100% - patient pays excess over Allowance.
• Outpatient	100% of Allowance	100% - patient pays excess over Allowance.
<b>(9) Maternity Benefits</b> (Calendar Year Deductible Applies)		
• Coverage	Treatment of pregnancy shall be on the same basis as the treatment for any illness. A hospital length of stay is allowed for the mother and newborn child for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section delivery. No authorization is required for a hospital length of stay that does not exceed these periods. Benefits for a shorter period will apply if the patient's attending provider, after consultation with the mother, has approved an earlier discharge.	
<b>(10) Substance Abuse Benefit</b> (Calendar Year Deductible Applies)		
• Coverage	Inpatient -100% of network allowance 100% Non-Network Provider Outpatient -100% of network allowance 100% Non-Network Providers Detox while inpatient -100% of network allowance 100% Non-Network	
<b>(11) Home Health Care Benefit</b> (Calendar Year Deductible Applies)		
• Coverage	100%, maximum visits 100 per calendar year. Maximum benefit per visit is \$35. Nutritional counseling maximum benefit is \$50 per calendar year.	100% - patient pays excess over Network Allowance. Maximum visits 100 per calendar year.
<b>(12) Hospice Care Benefit</b> (Calendar Year Deductible Applies)		
• Coverage	100%	100% - patient pays excess over Network Allowance.
<b>(13) Additional Accident Benefit</b> (Calendar Yr. Deductible <b>DOES NOT</b> Apply)		
• Coverage	100% up to \$300.00 for additional accidental benefit for charges incurred within 90 days of accident.	100% - patient pays excess over Network Allowance.
<b>(14) Well Adult Care Benefit</b> (Calendar Year Deductible Applies)		
• Coverage		
1. <u>Females</u> Age 18 and older, one annual cervical cancer screening examination, including PAP smear, a breast examination and for age 35 and older a mammogram, as recommended by the American Cancer Society.	100% of Network Allowance	100% - patient pays excess over Network Allowance.
2. <u>Males</u> PSA blood test and digital rectal examination, as recommended by a physician.	100% of Network Allowance	100% - patient pays excess over Network Allowance.

**\*\*IMPORTANT\*\***

**MEDICARE EXCEPTION** - Benefits payable under Medicare are determined before the benefits are payable under this Plan, unless federal law requires otherwise.

**III. IMPORTANT INFORMATION REGARDING  
YOUR PLAN BENEFITS**

**A. ENROLLMENT PROCEDURE**

It is important that the Plan Office has a completed enrollment card for you in its files. It is necessary that you complete an enrollment card before any claim can be processed. If you have not completed an enrollment card or if an additional card is needed, you may obtain one from your Local Union Office or from the Plan Office.

New Participants must also submit a marriage certificate to enroll their Spouse. It is important that you notify the Plan Office in the event that:

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

**IMPORTANT:** You can be held liable for benefit payments issued based on any incorrect information about your family member, such as failing to notify the Plan Office of a divorce. In addition, you may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney's fees, Plan Office costs, other administrative costs, and reasonable interest.

**B. HOW TO FILE YOUR CLAIMS**

1. Obtain a Claim Form. Obtain a claim form from the Plan Office at 445 Apple Street, Reno, Nevada 89502 (775-826-7200).
2. Sign and Complete Form. Complete and sign Part I of the Claim Form (the Employee's signature is required for Part I). Your Physician or Allied Health Professional may complete Part II, or you may attach an itemized bill to the Claim Form. The Plan requires that a minimum of one completed Claim Form be submitted each year for each Participant. You must use a separate Claim Form for each Participant.

**ALERT—ONE YEAR TO FILE CLAIMS**

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

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

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

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

After your claim has been processed, you will receive an *Explanation of Benefits Form* which gives you information about the status of your claim and any deductible remaining for the current year. The *Explanation of Benefits Form* will also inform you if the Plan Office needs additional information to complete the processing of your claim. The Fund has the right to obtain information necessary to evaluate claims, and may release such information as may be necessary to its consultants, attorneys, or other persons or organizations.

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

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

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

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

### **C. METHOD/FACILITY OF PAYMENT**

Except as specifically provided below, each Participant or beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any Benefit payable or any other right or interest under the Plan. The Fund is not required to recognize any such sale, transfer anticipation, assignment, alienation, hypothecation or other disposition. Any Benefit, right or interest is not subject in any manner to voluntary transfer by operation of law or otherwise, and is exempt from the claims of creditors or other claimants and from all order, decrees, garnishments, executions or other legal process or proceedings to the fullest extent permitted by federal law. Any Participant or beneficiary may direct that Benefits be paid to a provider of covered health services or supplies in consideration for services rendered or supplies furnished, or to any other agency that may have provided or paid for any Benefits provided under the Plan.

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

This ends the Summary portion of the Plan booklet. The formal Plan document begins on page 9.

## PLAN DOCUMENT

### U.A. LOCAL 350 HEALTH & WELFARE PLAN

#### **ARTICLE I: ESTABLISHMENT AND OPERATION OF THE PLAN**

##### **A. ESTABLISHMENT OF PLAN**

1. **Plan.** The Board of Trustees of the U.A. Local 350 Retiree Health and Welfare Trust established the U.A. Local 350 Retiree Health and Welfare Plan by this Plan Document effective as of September 1, 2014. The Plan is intended to be maintained for the exclusive benefit of Retired Participants and their Dependent Spouse. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA).

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

##### **B. PLAN MAY BE CHANGED**

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

1. Terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
2. Alter or postpone the method of payment of any benefit; and
3. Amend, terminate or rescind any provision of the Plan; and
4. Merge the Plan with other Plans, including the transfer of assets; and
5. Terminate insurance company; and
6. Restrict coverage to those living only in certain geographic areas.

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

##### **C. ADMINISTRATION AND OPERATION**

1. **Board of Trustees Responsibilities:** The Plan is administered by a Board of Trustees comprised of up to eight Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the Employer Association signatory to a Collective Bargaining Agreement with U.A. Local 350, and one-half of the Trustees, called "Union Trustees," are selected by U.A. Local 350. **The current Trustees are listed on page ii of this booklet.**

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



Only the Board of Trustees, and its authorized representatives, is authorized to interpret the Plan schedule of benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, Employer Associations, the Union and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Trustees. Plan definitions are in Article V beginning on page 28.

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

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

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

4. **Loss of Eligibility:** You and/or your Spouse could lose eligibility with the Plan if any monthly premium payments (if applicable) are not timely received by the Plan Office or you fail to meet the eligibility requirements.

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

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

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

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

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

8. **Plan Year.** The Plan Year commences **September 1** of each year and ends on **August 31** of the following year.

#### **D. YOUR RESPONSIBILITIES**

1. **Your Mailing Address.** Be sure to keep the Plan Office advised of changes in your address so that you can continue to receive Plan information because you may be entitled to benefits in the future.

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

#### **WARNING – FRAUD AGAINST PLAN**

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

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

4. **Privacy Protected Health Information.** There are Privacy Rules and forms to protect you based on recent legislation. If you wish to authorize someone other than yourself to access Plan information, you must complete the Authorization Form and return it to the Plan Office.

## **ARTICLE II: ELIGIBILITY RULES**

**SECTION 2.01 – RETIREE ELIGIBILITY.** If all the requirements below are met, coverage can be continued until the Retiree exhausts his/her Plan lifetime maximum benefit (\$5,000).

- A. For Retired Collectively Bargained Employee.** To be eligible for continued coverage under the U.A. Local 350 Retiree Health and Welfare Plan, a Retired Collectively Bargained Employee must meet the following requirements:
1. Has attained Retirement Age 60;
  2. Is receiving or entitled to received pension benefits from either the Plumbers and Pipefitters National Pension Trust Fund or the U.A. Local 350 Retirement Plan;
  3. Was eligible for benefits from the U.A. Local 350 Active Health and Welfare Plan for at least six (6) of the ten (10) years preceding retirement;
  4. Has either: (a) already elected COBRA at retirement and exhausted extended health and welfare benefits under the U.A. Local 350 Active Health and Welfare Plan or (b) waived COBRA and elected to enroll in the U.A. Local 350 Retiree Health and Welfare Plan;
  5. Must not be on the Out of Work List maintained by U.A. Local 350 at age 60 or thereafter;
  6. Has maintained and continues to maintain current membership with U.A. Local 350; and
  7. Is not working non-covered employment in the Plumbers and Pipefitters Industry.
- B. For Retired non-Collectively Bargained Employee.** To be eligible for continued coverage under the U.A. Local 350 Retiree Health and Welfare Plan, a Retired non-collectively bargained employee must meet the following requirements:
1. Has attained Retirement Age 62;
  2. Was eligible for benefits from the U.A. Local 350 Active Health and Welfare Plan for at least 24 months of the five (5) years preceding the date of retirement; and
  3. Has either: (a) already elected COBRA at retirement and exhausted extended health and welfare benefits under the U.A. Local 350 Active Health and Welfare Plan or (b) waived COBRA and elected to enroll in the U.A. Local 350 Retiree Health and Welfare Plan.

### **ALERT – COVERAGE AND BENEFITS CAN BE CHANGED**

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

**SECTION 2.02- COBRA CONTINUATION OF COVERAGE FOR SPOUSE.** A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), requires group health plans offer covered Participants and their Dependents the opportunity to elect to pay for a temporary extension of health coverage (called “COBRA Continuation Coverage”) in certain instances (called “qualifying events”) where coverage under the Plan would otherwise end. To receive this continuation coverage, the Participant and/or Spouse must make timely monthly payments directly to the Plan. **NOTE: If you are a retired participant who already received an offer of COBRA continuation coverage from the active health plan, upon your retirement, and either already elected or waived COBRA, these provisions do not apply to you. There is no second offer of COBRA.** Your COBRA eligibility time period is reduced by the number of months of free or subsidized coverage.

**A. CONTINUED COVERAGE.** "Continued coverage" shall mean only a Covered Person's coverage that the Covered Person keeps in force by the terms of this provision. The Covered Person's continued coverage options shall include health benefits only, medical coverage only, or medical plus any prescription drug coverage.

**B. QUALIFYING EVENTS.** For the Spouse of a Retiree covered by the Plan, COBRA provides continuation of coverage at the Spouse’s expense if Plan coverage is lost because of:

1. Retiree's death;
2. Divorce or Legal Separation from Retiree;
3. Retiree becomes entitled to benefits under Medicare.

**C. NOTIFICATION REQUIREMENTS.** A Covered Person who wants continued coverage because of a qualifying event shall notify the Plan Office of a change in family status within 60 days after it occurs. Within 44 days after the Covered Person notifies the Plan Office of a qualifying event, the Plan Office shall notify a Covered Person who is eligible for continued coverage of the following:

1. The Covered Person’s right of continued coverage;
2. The amount that shall be paid each month to continue the coverage; and
3. How, when and to whom the monthly payments shall be made.

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

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

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

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

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

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

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

1. The end of the 36-month period following the date of any of the following qualifying events: (a) death of Retiree, (b) divorce or legal separation from Retiree, or (c) becoming entitled to benefits under Medicare;
2. The end of the last month for which Dependent has made the required payment for continued coverage; the date on which any payment for continued coverage is not made in a timely manner. A payment shall be considered received in a timely manner if it is received within 31 days after becoming due;
3. The date Dependent becomes covered under another group health plan, after the date COBRA coverage is elected;
4. The date a Dependent becomes entitled to benefits under Medicare, after the date he/she first elects COBRA coverage;
5. The Plan or Trust is terminated;
6. Dependent voluntarily cancels coverage.

**ALERT**  
**Medicaid**  
**Offer Free or Low-Cost Health Coverage to Families**

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

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

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

Medicaid Website: <http://dwss.nv.gov/>  
Medicaid Phone: 1-800-992-0900

**SECTION 2.03 – COVERED DEPENDENT SPOUSE.** A Covered Dependent means a lawful spouse. If the Participant and spouse are legally separated or divorced, the spouse is no longer eligible for coverage. Generally, your spouse becomes covered by the Retiree Plan when your coverage starts. If you get married after your coverage starts, your spouse becomes eligible as of the date of marriage, provided the Participant has submitted an updated Enrollment Form adding the spouse along with a certified marriage certificate within 60 days of the date of marriage. *You are encouraged to provide proof of your marriage as soon as possible after you marry if you wish to add coverage for your new spouse.*

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

**NOTICE OF NEW DEPENDENT**

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

**SECTION 2.04 – RETIREE AND/OR DEPENDENT/COST OF COVERAGE.** A Retiree and his or her dependent spouse may be required to contribute toward the cost of the coverage provided in the Plan.

**SECTION 2.05 – TERMINATION OF DEPENDENT ELIGIBILITY.** A Dependent Spouse's eligibility terminates when the Participant's coverage terminates or when the individual ceases to meet the Plan qualifications of an eligible Dependent. Terminations occur as follows:

1. The date the person ceases to be a Dependent Spouse as defined in the Plan (such as the date on which your spouse is no longer married to you).
2. The date that the Participant who has a Covered Dependent Spouse ceases to be eligible under the Plan.

**ARTICLE III: MEDICAL BENEFITS (Covered Expenses)**

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

**For Retirees and Spouses not eligible for Medicare,** the Plan will pay covered medical expenses up to a \$5,000 lifetime maximum for each Retiree and Spouse which exceeds the amount of the deductible during a calendar year.

**For Retirees and Spouses eligible for Medicare,** the Plan will pay covered medical expenses which are not paid for by Medicare up to a \$5,000 lifetime maximum. (See *Coordination of Benefits* Section).

**SECTION 3.01 – CALENDAR YEAR DEDUCTIBLE.** The Deductible Amount applies during each calendar year and is satisfied when Covered Expenses incurred by a Covered Person exceeds the Deductible Amount specified as a Covered Plan Allowable. The calendar year deductible is waived when there is dual coverage and the Trust is the secondary plan. The Board of Trustees may amend or otherwise change the schedule of benefits at any time.

The deductible is the amount of Covered Expense which must be incurred during each calendar year before Major Medical Benefits are payable. The amount of the deductible for each Participant is the first \$100 of Covered Expense incurred in a calendar year only if not covered by Medicare. There is no family deductible.

Non-Covered expenses or expenses in excess of the Scheduled Allowance may not be used to satisfy the deductible. Only Covered Expenses incurred after a Participant's effective date of coverage may be used to satisfy the calendar year deductible.

#### *Deductible Carryover Provision*

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 calendar year.

### **PERCENTAGE PAYABLE AND COINSURANCE LIMIT**

After the deductible has been satisfied, the Plan shall pay the applicable percentage of the first \$5,000 (lifetime maximum) of Covered Expenses incurred by each Participant in a calendar year, and 100% thereafter for the remainder of that calendar year.

and the Plan pays at 100% on the particular Preferred Provider or Non-Preferred Provider that is utilized. Please refer to the *Preferred Provider Directory* that is updated by the Fund periodically.

### **SECTION 3.02 – INPATIENT HOSPITAL SERVICES.**

<p style="text-align: center;"><b>HOSPITAL AND MEDICAL REVIEW PROGRAM Provided by the Fund For Employees and their Eligible Dependents</b></p>
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**1. Any elective, non-emergency Hospital confinement is subject to Hospital Precertification.** This means that you or your Physician needs to notify the Professional Review Organization (PRO) PRIOR TO the Hospital admission. The PRO will determine whether or not the Hospital confinement is Medically Necessary, and if Medically Necessary, the number of pre-certified days eligible for Benefit coverage according to the terms of the Plan. (For the definition of Medically Necessary, please refer to page 1.)

The membership card which was issued to you by the Plan has the telephone number that your Physician will need in order to comply with the review requirements, or you can tell the Plan Office at (775) 826-7200. ***It is your responsibility to notify your Physician of this Hospital Precertification Program. Check with your Physician to ensure receipt of your pre-admission certification from the Professional Review Organization.***

**2.** Emergency confinements where prior approval from the PRO cannot be obtained are not subject to Hospital Precertification. However, if you or your Dependent are admitted to a Hospital for an Emergency confinement, you or the facility need to notify the Professional Review Organization as soon as possible after being admitted. The PRO will conduct a **Continued Stay Review (Concurrent Review)** to determine Medical Necessity.

**3.** Group health plans and health insurance generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. Benefits for a shorter period will apply if the patient's attending provider, after consultation with the mother, has approved an earlier discharge. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**4. The Continued Stay Review Program** is designed to assure that each day in the Hospital is Medically Necessary. After a Participant is admitted, Continued Stay Review takes place at intervals to determine if continued confinement is Medically Necessary. The length of stay your Physician proposes will be reviewed, and in most cases, the review confirms that intended care is Medically Necessary. If the intended care appears to be too long, the PRO may consult with your Physician to discuss the case further. If the Professional Review Organization determines that all or part of a confinement is not Medically Necessary and a Participant is nevertheless hospitalized during the non-certified period, **no Basic or Major Medical Benefits will be paid for confinement during the non-certified period.**

**5.** If a Participant is admitted to a Hospital that does not participate in a **Concurrent Review Program**, the confinement will be reviewed by the PRO after the Participant leaves the Hospital. If the PRO finds that all or part of the confinement was not Medically Necessary, **no Basic or Major Medical Benefits will be paid for confinement during the non-certified period.**

**6.** If you do not agree with the final determination of the Professional Review Organization, you may appeal directly to the Board of Trustees following procedures described in this booklet under **CLAIMS REVIEW PROCEDURES.**

**7. Exception to Hospital and Medical Review Program** – You are not required to comply with this Program when this Plan is the secondary payor (refer to the **COORDINATION OF BENEFITS** section of this booklet.

**8. LARGE CASE MANAGEMENT.** In some instances, a patient's needs may be met as well or better by offering an alternative treatment to an acute care Hospital confinement. Such alternatives could include Home Health Care, Hospice Care, or care in a Convalescent Facility or Skilled Nursing Facility. In those cases involving long-term disabling diseases or frequent readmissions, the Professional Review Organization (PRO), working with the patient's Physician, assesses whether alternative care is suitable for the patient and that health care services are carried out in a manner that ensures continuity and quality of care. There is no charge to the Participant for services of a case manager.

**9. PREFERRED PROVIDER PLAN – Hospital and Physician Contracting Program.** The Fund has entered into preferred provider arrangements with many Hospitals, Physicians, Allied Health Professionals, Pharmacies and other covered facilities to provide care and services to you and your Dependents at discounted fees. These arrangements entitle you to a discount when you use any of the Preferred Providers. By using Preferred Providers you will be helping to control health care expenses, which will help the Fund maintain current Benefit levels and minimize future cost increases for the Plan, as well as reduce costs for yourself.

The current list of Preferred Providers is contained in the separate Preferred Provider Listing, which is updated periodically, and furnished to Participants at no charge. Contact the Plan Office or refer to the Preferred Provider Listing for information on the percentages payable and the names of the current Preferred Providers.

**It is important to note that using a Non-Preferred Provider may result in a reduction of Benefits payable, and your out-of-pocket expenses will be significantly higher.** The Benefit payable for any Non-Preferred Provider is based on the Schedule of Allowances as updated from time to time by the Board of Trustees. You may contact the Plan Administrator for information regarding the allowances for specific services or procedures. If a Participant is admitted to a Hospital due to Illness or Injury, Benefits will be extended for:

- a. Daily room and board charges for each day of confinement.
- b. Charges for an intensive care unit.
- c. Hospital charges for other ancillary services and supplies provided during confinement. Hospital ancillary services or supplies may include (but are not limited to):



- General nursing services (not private duty nursing)
- Use of operating and cystoscopic rooms
- Surgical and anesthetic supplies, splints, casts and dressings
- Oxygen, drugs and medical equipment utilized during confinement
- Laboratory and x-ray examinations, physiotherapy and/or hydrotherapy
- Take-home medications prescribed by the attending Physician and dispensed by the Hospital pharmacy at the time of discharge

d. Confinements for a maternity related condition are considered as for any other condition. Benefits are extended for hospitalization of a new mother and her newborn infant for at least 48 hours following normal vaginal delivery, and at least 96 hours following cesarean section. Refer to the **HOSPITAL AND MEDICAL REVIEW PROGRAM** section of this booklet.

**10. Inpatient Treatment of Dental Injury.** Benefits are extended for services of a Physician (M.D.) or Dentist (D.M.D.) treating an accidental Injury to sound natural teeth that have not been extensively restored or have become extensively decayed or diseased, if treatment is performed:

- a. while the Participant is confined as an inpatient in a Hospital, and
- b. within one year of the date of the accident.

For the purposes of this Benefit, “sound natural teeth” means natural teeth (not teeth which have been restored with crowns, fixed or removable prosthodontics), which are free of active or chronic clinical decay, have at least 50% bony support, are functional in the dental arch and have not been excessively weakened by previous dental procedures.

Services to alter vertical dimension or restore occlusion to sound natural teeth are not covered.

**SECTION 3.03 – CONVALESCENT FACILITY OR SKILLED NURSING FACILITY.** If a Participant is confined in a Hospital for at least three consecutive days and is then admitted to a Convalescent Hospital or Skilled Nursing Facility within seven days of Hospital discharge, the Plan will reimburse up to 100% of the discounted rate for a PPO Provider or 100% of the Scheduled Allowance for a non-PPO Provider provided the Participant is under the care of a Physician and has been referred to the facility by a Physician.

**SECTION 3.04 – OUTPATIENT EMERGENCY CARE/OUTPATIENT SURGICAL CENTER.** Elective, non-emergency surgical procedures need to be reviewed by the Professional Review Organization (PRO) prior to surgery to determine Medical Necessity.

1. Hospital outpatient emergency room use, supplies, ancillary services, drugs and medicines, when required for Emergency Treatment of Illness or Injury.
2. Surgical procedure(s) performed in the outpatient department of a Hospital or at an Outpatient Surgical Center.
3. Outpatient hemodialysis, radiation therapy, and chemotherapy.

**SECTION 3.05 – MANIPULATION OF THE MUSCULOSKELETAL SYSTEM.** Benefits are extended for treatment of the vertebrae, spine, back or neck, including chiropractic services by a licensed Chiropractor, up to a maximum of 25 treatments per calendar year. **Covered Expenses are reimbursed as follows after Calendar year deductible is met:**

Contract Provider:	100% of the negotiated rates
Non-Contract Provider:	100% of the Scheduled Allowance shown in Appendix A

**Services of a Non-Contract Provider are limited to one session per calendar day as follows:**

1. In State -\$21.98 per visit and Out of State -\$25.20 per visit.

**SECTION 3.06 – SURGICAL CARE.**

**Elective, non-emergency surgical procedures performed at a facility need to be reviewed by the Professional Review Organization (PRO) prior to surgery to determine Medical Necessity.**

**Covered Expenses of the opening Physician for surgical or radiotherapy procedures include:**

1. Services rendered for surgery or radiotherapy by a primary operating surgeon or assisting surgeon. Benefits for a second Physician or Surgeon on the same case at the same time are payable when the attendance is warranted by a need for supplementary skills.
2. When regional or general anesthesia (not including local infiltration anesthesia) is provided by the primary operating or assisting Physician, the amount payable is determined by the “basic” value for anesthesia without added value for time.
3. If an incidental procedure (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the benefit will be based on the major procedure only.
4. When multiple or bilateral surgical procedures, which adds significant time or complexity, are performed at the same operative session, Covered Expense will not exceed 100% (full value) for the major procedure, plus 50% for a second procedure, plus 25% for a third procedure, plus 10% for a fourth procedure, plus 5% for successive procedure(s).
5. Benefits for preoperative, surgery, and/or postoperative care will be based on “Surgery Value Guidelines” as outlined in *Relative Values for Physicians*, and as updated from time to time.

Under federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers all stages of reconstruction of the breast on which the mastectomy was performed, surgery on the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of a mastectomy, including lymphedemas. This coverage is subject to the Plan’s calendar year deductible and coinsurance provisions.

**SECTION 3.07 – PROFESSIONAL SERVICES AND SUPPLIES.**

**Covered Expenses for professional services and supplied include:**

1. Professional ambulance service when required for transportation to or from a local Hospital or Convalescent Hospital where treatment is given;
2. Services rendered by a Physician for medical treatment of Illness or Injury;
3. Services of a Registered Nurse (R.N.), provided the services rendered are not custodial in nature and cannot be performed by a less qualified person. Services of a licensed physiotherapist, when prescribed by a Physician;
4. Diagnostic x-rays, radium or radioactive isotope therapy performed by a Physician or Radiologist, or diagnostic laboratory examinations performed by a Physician or pathologist;

5. Trigger point injections performed by either a Contract Provider or a Non-Contract Provider are limited to a maximum of 1 visit per day and 15 visit per calendar year. No more than 5 trigger point injections are payable per visit.
6. Administration of oxygen, casts, splints, and surgical dressings.
7. Blood Transfusion, including blood processing and cost of un-replaced blood and blood products.
8. Radiation therapy and chemotherapy.
9. The initial External Breast Prosthesis purchased within one year after a mastectomy is performed is covered under regular Plan benefits. Two Post-Mastectomy Bras are covered per calendar year with doctor's orders.
10. Two support hose stockings are covered per calendar year if medically necessary and supported by a doctor's orders.
11. Following cataract surgery, the first lense replacement is covered.
12. Wigs due to loss of hair after radiation therapy or chemotherapy up to \$370 lifetime maximum.
13. Epidurals for pain management (not pregnancy). Provided by a Contract Provider or Non-Contract Provider are limited to a maximum of 3 injections per calendar year.

### **SECTION 3.8 – PROSTHETIC DEVICES, MEDICAL EQUIPMENT AND SUPPLIES.**

**Covered Expenses are defined as the rental or purchase of prosthetic devices, durable medical equipment and supplies, which are:**

1. Prosthetic devices and braces (including surgically implanted devices and corrective appliances), excluding replacements or repairs; or
2. Equipment and those supplies, which are:
  - ordered by a Physician,
  - usable only by the Patient,
  - of no further use when medical need ends,
  - not primarily for the comfort or hygiene of the Participant,
  - not for environmental control,
  - not for exercise,
  - manufactured specifically for medical use,
  - approved as Medically Necessary treatment, as determined by the Fund, and
  - not for prevention purposes.
3. Custom molded orthotics when provided by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or Podiatry (D.P.M.) and must be ordered by a M.D., D.O., or D.P. M. for treatment of feet.

Fees incurred for maintenance agreements related to the purchase of oxygen concentrators are considered to be Covered Expense. Rental charges that exceed the Usual, Customary and Reasonable purchase price for durable medical equipment are not Covered Expenses.

### **SECTION 3.9 – MENTAL HEALTH BENEFITS.**

The maximum number of days for which benefits will be payable for hospitalization due to mental health disorder is 60 days per 24 months of inpatient care per Participant per calendar year.

Outpatient psychotherapy and psychological testing is payable at 100% of discounted fees for Contract Providers and 100% of schedule allowance for Non-Contract Providers.

### **SECTION 3.10 – HOME HEALTH CARE BENEFIT.**

**Home Health Care Services need to be reviewed by the Professional Review Organization (PRO) to determine Medical Necessity.**

The Plan will extend a benefit for Medically Necessary home health care or home I.V. therapy services rendered by a licensed Home Health Care Agency, for care that would have been covered under the Plan if services were performed in a Hospital or Convalescent Hospital.

Covered Expenses for care rendered by a *Preferred Provider* is reimbursed at 100% of discounted fees. Covered Expenses for care rendered by a *non-Preferred Provider* is reimbursed at 100% of the Scheduled Allowance, subject to the calendar year deductible.

The Home Health Care Benefit is subject to the following provisions:

- A treatment plan of home health care or home I.V. therapy must be reviewed by the Professional Review Organization (PRO) before treatment starts in order to determine Medical Necessity. If precertification is not received, services rendered are subject to retrospective review by the PRO.
- Certification must be provided to the Plan that services are prescribed by a Physician to be performed in the Participant's home. Periodic recertification and patient prognosis reports must be furnished by the Home Health Care Agency and/or Physician when requested by the Plan.

The Home Health Care Benefit is not payable for custodial services to assist in meeting personal, family, or domestic needs.

### **SECTION 3.11 – TREATMENT FOR ALCOHOL OR SUBSTANCE ABUSE.**

**ALERT**  
***Any elective, non-emergency Hospital confinement is subject to Hospital Precertification.***

Benefits are extended for the treatment of alcohol, drug, or chemical dependency on the same basis as Benefits are paid for treatment of any other condition, except as follows:

Inpatient Care:

*Contract Provider:*

100% of the negotiated rates

*Non-Contract Hospital outside Reno/Sparks*

100% of the Scheduled Allowance

**Treatment of Alcohol or Substance Abuse is limited to the following maximums:**

- (1) One detox treatment per calendar year. This treatment can be an inpatient hospital setting or part of a residential substance abuse counseling treatment. Inpatient hospital setting or residential substance abuse counseling treatment payable at 100% of contract rate for PPO providers and 100% of Out of Network Fee

Schedule for non-PPO provider. Pre-certification is required.

(2) One inpatient confinement per calendar year per participant – up to Twenty-Eight Day Alcohol and/or Substance Abuse Counseling/treatment. Pre-certification is required.

**SECTION 3.12 – DIALYSIS.** Participants must apply for Medicare as a secondary payer within the first 90 days of being diagnosed with ESRB.

The Fund will pay up to the lifetime maximum of \$5,000 for covered dialysis services rendered at a PPO or Non-PPO provider.

**SECTION 3.13 – ACUPUNCTURE.** Medically necessary treatment (does not include herbal medications/injections) by an OMD (Doctor of Oriental Medicine) or an Acupuncturist licensed and certified in the State of Service for up to 15 visits per calendar year subject to the calendar year deductible.

**SECTION 3.14 – EMERGENCY ROOM – THE FIRST \$25.00 CHARGE PER EMERGENCY VISIT IS PAID BY THE PARTICIPANT.** Emergency room treatments will be limited to six treatments per calendar year per person.

**SECTION 3.15 – PHYSICAL THERAPY.** Must be provided by a licensed physical therapist and is limited to 30 physical therapy treatments per calendar year. The treating physician must provide the physical therapist with a written prescription specifying frequency of treatment and length of time. A copy of the prescription must be attached to the claim.

**SECTION 3.16 – PERIOD OF DISABILITY.** Outpatient Emergency Accident benefits described in Section 3.02 and Ambulance Service benefits described in Section 4.06 are provided only once during any Period of Disability.

- a. A Period of Disability begins:
  - (1) When a Participant is confined in a Hospital or convalescent hospital as a registered inpatient; or
  - (2) When a Participant undergoes surgery for treatment of an Illness or Injury.
  
- b. A Period of Disability ends:
  - (1) For a Retiree: when a Retiree resumes active work.
  - (2) For a Dependent: when the Dependent has not been confined in a Hospital or Convalescent Hospital as a registered inpatient, or undergone a surgical procedure, during a period of ninety (90) consecutive days.

Consecutive Periods of Disability which are due to totally unrelated Injuries or Illness will be considered separate Periods of Disability/

**SECTION 3.17 – OUTPATIENT EMERGENCY ACCIDENT.** The Fund will pay up to \$100 during a Period of Disability to Hospital outpatient Emergency treatment.

Covered Expenses shall include only those Hospital expenses for medical services and supplies provided to a Participant during Emergency outpatient treatment of bodily Injuries, provided within 24 hours after such Injuries were sustained.

**SECTION 3.18 – ADDITIONAL ACCIDENT CARE.** Covered accident charges shall include only the following items incurred for Medically Necessary treatment of an Injury within 90 days after the accident.

**Covered Expenses are reimbursed at 100% to a maximum benefit payable of \$300 per Participant per accident for:**

- a. professional ambulance service to transport the Participant to or from a local Hospital where treatment is given;
- b. inpatient and outpatient Hospital expenses;
- c. an operating Physician and any assisting Physician for professional services for a surgical or radiotherapy procedure, and the charge of a Physician anesthesiologist or a registered nurse anesthetist for anesthesia and its administration in connection with the performance of a surgical procedure;
- d. a Physician for medical or dental services;
- e. a registered nurse or licensed physiotherapist for professional services rendered in the performance of nursing or physiotherapy;
- f. medical or dental supplies.

**SECTION 3.19 - HOSPICE CARE.** Basic Medical Benefits are extended for Hospice services performed by an approved Hospice Agency for Participants who are homebound in the latter stages of a terminal illness (defined as a terminally ill Participant who has a life expectancy of six months or less) and to eligible members of the terminally ill Participant's family.

Hospice Care Benefits are payable only for Covered Expenses incurred during a period for which the Plan validates a Physician's certification that the Participant is terminally ill, and during the Bereavement Period.

The maximum Benefit payable for all combined Hospice Care services is \$5,000 (lifetime maximum). Covered Expenses (except bereavement counseling) of a *Preferred Provider* are reimbursed at 100% of discounted fees. Covered Expenses (except bereavement counseling) of a *non-Preferred Provider* are reimbursed at 100% of the Scheduled Allowance.

**Covered Expenses include only the following items:**

1. Inpatient confinement in a Hospice, for up to a total of 8 days of inpatient Respite Care. "Respite Care" is care that is furnished a terminally ill Participant so that the family unit may have relief from the stress of caring for the terminally ill Participant.
2. The following Home Health Care services:
  - professional services of a Registered Nurse, a licensed practical nurse, or a licensed vocational nurse;
  - services of a home aide;
  - physical, occupational, speech, respiratory or rehabilitation therapy;
  - rental (but not repair or replacement) of durable medical equipment; not to exceed the purchase price of the equipment;
  - laboratory services, medical supplies, oxygen, drugs and medicines prescribed by a Physician; and
  - nutritional counseling and special meals.
3. Medical Social Services furnished to a terminally ill Participant and his or her immediate family. "Medical Social Services" means those counseling services furnished by a psychiatrist, psychologist, or staff member of a licensed social services agency.
4. Bereavement counseling by a licensed or certified social worker or licensed pastoral counselor to assist the family unit during the Bereavement Period in coping with the death of the terminally ill Participant. The "Bereavement Period" is the 12 month period that begins on the date of death of the terminally ill Participant.

Covered Expenses for bereavement counseling are reimbursed at 100% to a maximum benefit payable of \$12.50 for each session of bereavement counseling. The Plan will extend Basic Medical Benefits for a maximum of 25 such sessions for the family unit.

**SECTION 3.20 – X-RAY AND LABORATORY.** Charges for x-ray and laboratory services performed which a physician has prescribed.

**SECTION 3.21 – BLOOD.** Charges for whole blood or blood plasma, and the cost of its administration.

**SECTION 3.22 – ALLERGY SERUM.** Charges for allergy serum preparation and its administration.

**SECTION 3.23 – NURSING SERVICES.** Charges made by a Registered Nurse or Licensed Vocational Nurse, for nursing services medically required and prescribed by a physician, while confined as an Inpatient.

**SECTION 3.24 – MEDICALLY NECESSARY SUPPLIES.** Charges for all Medically Necessary supplies such as casts, splints, trusses, braces, crutches, and surgical dressings and charges for artificial limbs and eyes replacing those initially lost due to illness or injury, and replacement if determined Medically Necessary.

**SECTION 3.25 – CHEMOTHERAPY.** Charges for chemotherapy as Medically Necessary, excluding experimental or research drugs.

**SECTION 3.26 – RENAL DIALYSIS.** Charges for services and supplies for renal dialysis.

**SECTION 3.27 – SMOKING CESSATION PROGRAM.** Regular Plan benefits are payable up to a lifetime maximum benefit of \$250 for participation in a smoking cessation program, prescription drugs, or any over the county treatments.

**SECTION 3.28 – PREVENTATIVE COLONOSCOPIES.** Preventative Colonoscopies will be a covered benefit under the Plan for all eligible Participants age 50 and over. This benefit will be subject to calendar year deductible and lifetime benefits.

The benefits described in this Article are provided for Covered Expenses for treatment of an Illness or Injury. An expense is deemed to have been incurred on the date the Participant receives the service or supply for which a charge is made. Major Medical benefits provide comprehensive coverage for Covered Expenses that are not paid by the Basic Medical benefits.

**SECTION 3.29 – COVERAGE OF CONTRACEPTIVE/PRESCRIPTION REQUIRED.**

**This Notice explains a change to the provisions of your Plan. Please be sure that you and your family read this Notice in order to understand the change.**

Oral and injectable contraceptives and devices that require a physician's written prescription or a visit to the physician's office. To the extent covered charges do not exceed reasonable charges as determined by the Plan Office, the Plan will pay 100% of covered charges incurred. All other terms and conditions under the Plan's prescription drug benefit program will continue to apply. A medical claim should be submitted by the doctor's office for the visit and any drugs that must be administered by a doctor. Medical benefits will be subject to all other terms and conditions under the Plan's medical benefits.

## **ARTICLE IV: MEDICAL PLAN EXCLUSIONS AND GENERAL LIMITATIONS**

In addition to any exclusion and limitations described elsewhere in this booklet, the following Exclusions and General Limitations are applicable to all Benefits provided under this Plan. **No Plan Benefits are extended for any of the following:**

1. **No Eligibility.** Care, treatment or services for which, regardless of the Participant's financial ability, there is no legal obligation of the Participant to pay or for which no charge is made in the absence of eligibility for Benefits. There is no Dependent Children coverage under the Retiree Plan.
2. **Government Institutions.** Care, treatment or services which are furnished under any governmental institution or agency except to the extent that such services are reimbursable to the Veterans Administration for non-service connected conditions under 38 U.S.C. 629.
3. **Other Benefits.** Expenses incurred which may be paid under any other Benefit provided by the Fund.
4. **Government Services.** Any services provided by a local, state or federal government agency, or any services for which payment may be obtained from any other local, state or federal government agency.
5. **Other Policy or Plan.** Expenses incurred for which benefits are provided under any other group insurance policy, other medical benefits or service plan, union welfare plan or employee benefit plan for which an employer directly or indirectly makes contributions or payroll deductions.
6. **War, Crimes, Illegal Acts, Special Circumstances.** Expenses due to or resulting from: (1) Illness or Injury that is intentionally self-inflicted, while sane or insane, unless the injury resulted from an act of domestic violence or a medical condition such as depression (2) war, act of war, armed invasion or aggression, (3) nontherapeutic release of nuclear energy, or (4) a Participant committing or attempting to commit a felony or while engaging in the commission of a crime (no conviction is required). Exclusion does not apply to terms 1 and 4, when such illness or injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).
7. **Work-Related Injuries.** The Plan pays for benefits for illnesses and injuries that are not work-related. The Plan does not pay for expenses relating to any Illness or Injury for which benefits of any nature are found to be recoverable, either by adjudication or settlement, under any Workers' Compensation law, employer's liability law, or occupational disease law, even if a Participant fails to claim their right to such benefits. Benefits may be advanced while a claim is pursued if a Participant assigns to the Plan all rights to medical reimbursement under such laws. Thus, if a claim is denied under this section and you're appealing a ruling by the Worker's Compensation commission, you may be eligible to receive benefits under a Subrogation/Reimbursement Agreement. If you believe you qualify for such an Agreement, you may contact the Fund Office. (Please refer to Article 7.10 Third Party Recovery/Subrogation/Reimbursement).

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

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



any services or supplies not considered legal in the U.S.

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

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

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

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

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

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

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

**16. Hearing Devices.** Expenses incurred for hearing devices or the fitting of hearing devices.

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

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

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

**20. Physical Exams.** Expenses for routine physical examinations, or any examinations required for obtaining or maintaining employment, insurance or governmental licensing, school or sporting activities.

21. **Immunizations for Travel.** Expenses for immunizations required solely for travel outside the United States.
22. **Certain Newborn Care.** Any care of a newborn child after the age 2 other than for a treatment of an Illness or Injury. This Plan complies with federal law that prohibits a plan from requiring a health care practitioner to obtain authorization to prescribe a hospitalization in connection with childbirth to less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarean section.
23. **Excess of Annual Maximums.** Amounts in excess of: (1) the \$5,000 annual maximum applicable to treatment of substance abuse, or (2) amounts in excess of the Major Medical Lifetime Maximum Benefit.
24. **Sex Changes.** Expenses related to sexual reassignment, procedures or treatments designed to alter physical characteristics to those of the opposite sex, or any resulting medical complications.
25. **Elective Abortion.** Expenses in connection with an elective termination of pregnancy, except (1) where the life of the mother is at risk or (2) medical complications arising from elective termination of pregnancy.
26. **Pregnancy of a Dependent Child.** Expenses in connection with the routine normal pregnancy of a Dependent daughter or other non-spousal dependent.
27. **Vision-Related Items.** Eye glasses, contact lenses, optometric services, vision therapy including orthoptics (except for estropia, exotropia or strabismus), routine eye examinations, eye refractions for the fitting of glasses, or radial keratotomy, except as provided under Vision Care Benefits. Also any surgical procedure to correct nearsightedness or farsightedness. Eye surgery for refractive error, such as Lasik.
28. **Dental Implants.** Dental implants or services in connection with dental implants.
29. **Modification to Home or Vehicles.** Expenses incurred for modifications to your home, property, or vehicles regardless of their therapeutic or ease-of-access value, including without limitation, elevators, ramps, stairs or car hand controls.
30. **Speech or Occupational Therapy.** Speech therapy or occupational therapy, except rehabilitation treatment following a stroke or Injury.
31. **Myofunctional Therapy.** Myofunctional therapy.
32. **Surrogate Pregnancy.** Treatment related to a Surrogate Pregnancy in which the Participant and/or Dependent Spouse act as Surrogate in a surrogate pregnancy is excluded. This exclusion applies to any and all costs related in any way to the surrogate pregnancy, including delivery costs. This Exclusion also applies to any and all complications related to the surrogate pregnancy.
33. **Temporomandibular Joint Dysfunction (TMJ).** Procedures and services for the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) or disturbances of the temporomandibular joint.
34. **Human Papilloma Virus (HPV).** HPV (Human Papilloma Virus) vaccine and HPV lab test.
35. More than one home or office visit by a physician or an allied health care professional or telephone consultations between you and your physician.
36. **Non-listed Expenses.** Services not specifically listed in this Plan as Covered Expenses.

## **ARTICLE V: DEFINITIONS**

**SECTION 5.01 – ACTIVE EMPLOYEE.** Means each employee who meets the eligibility rules of the U.A. Local 350 Health and Welfare Plan for Actives.

**SECTION 5.02 – ALCOHOL/SUBSTANCE ABUSE FACILITY.** Means any facility for treatment of abuse of alcohol or drugs which is certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources.

**SECTION 5.03 – ALLIED HEALTH PROFESSIONAL.** Means only a person shown in the list following and only if (1) the person is licensed and practices within the scope of their license, and (2) the person is not a Relative to the Participant and does not have the same legal address as the Participant.

- (a) A dentist (D.D.S. OR D.M.D.).
- (b) A podiatrist (D.P.M.).
- (c) A psychologist (Ph.D), a licensed clinical social worker (L.C.S.W.), or a marriage, family and child counselor (M.F.C.C.).
- (d) A registered nurse (R.N.).
- (e) An optometrist (O.D.).
- (f) A registered physical therapist (R.P.T.).
- (g) A chiropractor or chiroprapist (D.C.).
- (h) For acupuncture services only, a doctor of Traditional Chinese Medicine (O.M.D. or C.A.), or where licensing is not required, certification by the National Certification Commission for Acupuncturists (NCCA).
- (i) A Pharmacist.
- (j) An optician.
- (k) A certified alcohol and drug abuse counselor (C.S.A.C.).

**SECTION 5.04 – COLLECTIVE BARGAINING AGREEMENT.** Means that labor agreement between the U.A. Local 350 and an Employer, which provides for Contributions to this Fund in accordance with the provisions of the Trust Agreement.

**SECTION 5.05 – CONCURRENT REVIEW.** “Concurrent Review” or “Continued Stay Review” means the process whereby the Professional Review Organization (PRO) under contract to the Fund determines the number of pre-certified days considered Medically Necessary and eligible for unreduced Benefit coverage at a particular level of care for a Participant under inpatient Hospital care, according to the terms of the Plan.

**SECTION 5.06 – PROVIDERS.** “Contract Provider” or “Participating Provider” means a Hospital, Physician, Allied Health Professional, Pharmacy, or other covered facility that has a contract for negotiated rates in effect with the Fund under the Preferred Provider Plan. A “Non-Contract Provider” does not participate in the Preferred Provider Plan.

**SECTION 5.07 – CONTRIBUTING EMPLOYER OR “EMPLOYER”.** Means any business entity that is required by a Collective Bargaining Agreement between the Union and the Employer to make payments into this Trust. “Contributing Employer” shall also include any other business entity whose participation is permissible under applicable laws (including the Union on behalf of its own employees) and which contributes to the Trust with the approval of the Board of Trustees and in accordance with such conditions as it may from time to time require to assure the financial integrity of the Trust and equity among Employers and Participants.

The Board of Trustees may require any Employer to sign a Collective Bargaining Agreement acceptable to it before crediting the Employer's Contributions. Such Agreement shall contain any conditions applicable to the Employer's participation that the Joint Board of Trustees may require.

**SECTION 5.08 – CONVALESCENT HOSPITAL.** Means only an institution that meets all the following tests:

- (a) primarily provides skilled nursing care to registered inpatients under 24 hour-a-day supervision of a Physician or Registered Nurse;
- (b) has available at all time a Physician who is a staff member of a Hospital;
- (c) has on duty 24 hours a day a Registered Nurse, licensed vocational nurse, or skilled practical nurse, and has on duty at least eight hours a day a Registered Nurse;
- (d) maintains a daily medical record for each patient;
- (e) complies with all licensing and other legal requirements; and
- (f) is not, except incidentally, a place of rest, a place for custodial care for the aged, for drug addicts, for alcoholics, a place for the care of persons with mental, nervous or emotional disorders, a hotel or similar institution.

**SECTION 5.09 – COVERED EXPENSES.** Means the charges or expenses incurred by an eligible Participant, which are:

- (a) made for care and treatment of a non-occupational Illness or Injury; and
- (b) Medically Necessary; and
- (c) expressly covered under provisions of the Plan or which are not expressly excluded.

**SECTION 5.10 – “DRUGS” or “PRESCRIPTION DRUGS”.** Means any article which may be lawfully dispensed as provided under the Federal Food, Drug and Cosmetic Act, including amendments thereto, only upon a written or oral prescription of a Physician or Allied Health Professional licensed by law to administer it.

**SECTION 5.11 – EMERGENCY.** Means a medical condition which, if not immediately treated, is likely to result in any of the following: death, permanent disability, prolonged temporary disability or unwarranted prolongation of treatment; increased risk by requiring more complex or hazardous treatment; development of chronic illness; or inordinate physical or psychological suffering.

**SECTION 5.12 – “EMPLOYEE BENEFITS” or “BENEFITS”.** Shall mean any of the following types of Benefits: Basic and Major Medical, Prescription Drug; Vision Care; and Dental Care. The Trustees may provide such Benefits by insurance or by any other lawful means or methods upon which they may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such Benefits as can be purchased with the Contributions available, together with any available reserves of the Trust.

**SECTION 5.13 – “EXPERIMENTAL” or “EXPERIMENTAL PROCEDURE”.** Shall mean any of the following:

- (a) Any procedure, equipment, treatment or course of treatment, or drug or medicine that is considered by a majority of the medical community in Nevada to be under investigation or is limited to research.
- (b) Techniques that are generally in use only at centers that are regularly engaged in carrying out disciplined clinical efforts and scientific studies.
- (c) Procedures that are not proven in an objective way to have therapeutic value or benefit.
- (d) Any procedure, equipment, treatment or course of treatment for which reliable evidence shows that prevailing opinion among experts is that further studies or clinical trials are necessary to determine efficacy or efficacy as compared with a standard means of treatment or diagnosis.  
“Reliable Evidence” shall mean only published reports and articles in peer reviewed authoritative medical and scientific literature and the written protocol(s) used by the treating facility or another studying substantially the same medical treatment or procedure.

**SECTION 5.14 – FUND.** Means the U.A. Local 350 Retiree Health and Wealth Fund.

**SECTION 5.15 – GROUP PLAN.** Means any plan providing benefits of the type provided by this Plan that is supported wholly or in part by employer payments.

**SECTION 5.16 – HOME HEALTH CARE AGENCY.** A licensed Home Health Care Agency shall meet all of the following requirements:

- (a) it must primarily provide skilled nursing services and other therapeutic services under the supervision of Physicians and Registered Nurses;
- (b) it must operate according to policies established by a professional group, including Physicians and Registered Nurses, which governs the services provided;
- (c) it must maintain clinical records on all patients; and
- (d) it must be licensed by the jurisdiction where it is located, operate according to the laws of that jurisdiction which pertain to agencies providing Home Health Care, and be certified as a Home Health Care Agency by Medicare.

**SECTION 5.17 – “HOSPICE” or “HOSPICE AGENCY”.** Shall mean a facility or organization which administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care during the final stages of terminal illness and during bereavement. The facility or organization must be certified by the National Hospice Organization, Medicare, and local licensing organizations.

**SECTION 5.18 – HOSPITAL.** Means an institution operated pursuant to law meeting the following requirements:

- (a) it is equipped with permanent facilities for diagnosis, major surgery, and 24-hour continuous nursing service by registered professional nurses (R.N.) and 24-hour continuous supervision by a staff of Physicians licensed to practice medicine (other than physicians whose license limits their practice to one or more specified fields), and it maintains a clinical record for each patient;
- (b) it is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a place for custodial care or rest, nursing home, a place for the aged, a hotel or similar institution;
- (c) for the purposes of Benefits provided for mental health treatment, an institution that lacks permanent facilities for surgery will be considered a Hospital and an institution that is primarily a place for the care of persons with mental health conditions will be considered a Hospital, provided that such institutions meet all the other requirements applied to Hospitals; and
- (d) it complies with all licensing and other legal requirements, and is recognized by the Secretary of the United States Department of Health and Human Services pursuant to Medicare.

**SECTION 5.19 – “HOSPITAL PRECERTIFICATION” or “HOSPITAL STAY REVIEW”.** Shall mean the process whereby the Professional Review Organization (PRO) under contract to the Plan determines the Medical Necessity of a Participant’s elective non-Emergency confinement to a Hospital, and if Medically Necessary, the number of pre-certified days eligible for Benefit coverage according to the terms of the Plan prior to such elective confinement actually occurring.

**SECTION 5.20 – HOUR BANK ACCOUNT.** Means the account established for an Active Employee to which are credited all hours worked for Contributing Employers for which Contributions are made, or are required to be made to the Fund on an Active Employee’s behalf.

**SECTION 5.21 – ILLNESS.** Means a non-occupational bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause.

**SECTION 5.22 – INJURY.** Means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

**SECTION 5.23 – LARGE CASE MANAGEMENT or CASE MANAGEMENT.** Means the process whereby the care for an Illness or Injury is focused on the most appropriate plan of treatment and/or treatment alternatives for long-term, repetitive or medically specific instances of care.

Services and supplies are “**Medically Necessary**” or provided due to “**Medical Necessity**” if such service or supply is determined by the Plan to be:

- (a) Appropriate and necessary for the symptoms, diagnosis or treatment of a Illness, Injury or condition; and
- (b) Not Experimental, educational, or investigational; and
- (c) Not primarily for the convenience of the Participant, the Participant’s Physician or another provider; and
- (d) Within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in Nevada; and
- (e) The most appropriate supply or level of service which can safely be provided; and
- (f) When applied to hospitalization, Medically Necessary means that the symptoms or condition cannot safely and adequately be treated on an outpatient basis; and
- (g) The fact that a Physician or Allied Health Professional may prescribe, order, recommend or approve a service or supply does not of itself make such a service or supply Medically Necessary, even though it is not specifically listed as an exclusion.

**SECTION 5.24 – “MEDICARE” or “FEDERAL MEDICARE”.** The term “Medicare” or “Federal Medicare” shall mean the insurance program established by Title XVIII, Unites States Social Security Act of 1965, as originally enacted or as subsequently amended.

**SECTION 5.25- PARTICIPANT.** Shall mean any person eligible for Benefits under the Plan, whether as an Eligible Retiree or Eligible Dependent.

**SECTION 5.26 – “PHARMACIST” or “LICENSED PHARMACIST”.** Means an individual who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

**SECTION 5.27 - PERMANENT AND TOTAL DISABILITY.** The term “Physician” or “Surgeon” or “Doctor” means a licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or an Allied Health Professional licensed to practice in the state in which he practices and practicing within the scope of his license. If and where the term “Physician” is specifically defined in a Benefit provision, that definition shall prevail over this general definition.

**SECTION 5.28 – PLAN.** Shall mean this document titled the U.A. Local 350 Retiree Health and Welfare Trust Fund Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

**SECTION 5.29 – PLAN YEAR.** Means September 1 of any year to August 31 of the succeeding year.

**SECTION 5.30 – PREFERRED PROVIDER PLAN.** Means a program whereby specific providers contract with the Fund to provide Medically Necessary services or supplies to Participants payable on a negotiated rate basis, approved by the Trustees and amended from time to time.

**SECTION 5.31 – PREGNANCY.** Means all pregnancies, childbirth, and voluntary termination of pregnancy for a Retiree or Dependent Spouse only. Complications of Pregnancy will be considered as any other Illness.

**SECTION 5.32 – COMPLICATIONS OF PREGNANCY.** Means all physical ailments suffered as a direct result of the pregnancy, outside of the effects of a normal pregnancy from a medical viewpoint. Complications of Pregnancy shall include, but are not be limited to, conditions such as acute nephritis, nephrosis, cardiac compensation, missed abortion, ectopic pregnancy which terminated, Caesarian section, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similarly medically diagnosed conditions. Complications of Pregnancy shall not include false labor, Physician-prescribed rest during the period of pregnancy, morning sickness and similar conditions not constituting a classifiably distinct Complication of Pregnancy.

**SECTION 5.33 – “PROFESSIONAL REVIEW ORGANIZATION” or “PRO”.** Means a third party retained by the Plan to conduct Hospital Stay Review, Continued Stay Review, and Large Case Management under the Plan.

**SECTION 5.34 – REGISTERED NURSE.** Shall mean a person licensed as a Registered Nurse (R.N.) under the appropriate laws and who is not a Relative to the Participant and who does not have the same legal address as the Participant.

**SECTION 5.35 – RELATIVE.** Means the Participant’s spouse, parents, children, siblings, or anyone residing in the same household as the Participant.

**SECTION 5.36 – RETIRED EMPLOYEE.** Means each retired person who meets the eligibility rules of the Plan.

**SECTION 5.37 – SCHEDULED ALLOWANCE.** Means the description of covered benefits payable under the Plan and the amount payable for such benefits as approved by the Board and amended from time to time.

**SECTION 5.38 – “SKILLED NURSING FACILITY” or “EXTENDED CARE FACILITY”.** Means an institution primarily engaged in providing patients with (i) skilled nursing care and related services, or (ii) services for the rehabilitation of injured, disabled or sick persons, and which meets all of the following requirements:

- (a) it is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours-a-day supervision of a Physician or a Registered Nurse;
- (b) has available at all times a Physician who is a staff member of a Hospital;
- (c) has on duty 24 hours a day a Registered Nurse, licensed vocational nurse, or skilled practical nurse, and has on duty at least eight hours a day a Registered Nurse;
- (d) maintains a daily medical record for each patient;
- (e) complies with all licensing and other legal requirements and is recognized by the Secretary of the United States Department of Health and Human Services pursuant to Medicare; and
- (f) is not, except incidentally, a place of test, a place for custodial care for the aged, or drug addicts, for alcoholics, a place for the case of persons with mental health conditions, a hotel or similar institution.

**“Outpatient Surgical Center” or “Surgi-Center”** shall mean a state licensed facility that is not a Hospital, but meets all of the following requirements:

- (a) it provides surgical facilities for ambulatory, outpatient surgical care, providing continuous Physician and Registered Nursing services while patients are in the center;
- (b) it is equipped with permanent surgery facilities and is staffed by Registered Nurses, Physicians and anesthesiologists licensed to practice medicine; and

- (c) it is a place other than a Physician's office, and it does not provide accommodations for patients to stay overnight.

**“Total Disability” or “Totally Disabled”** means:

- (a) As a result of Injury or Illness, an Employee is unable to engage in any and every duty pertaining to his customary occupation and is performing no work of any kind for profit.
- (b) As a result of Injury or Illness, a Dependent is unable to engage in substantially all regular and customary activities usual for a person of similar age and family status.

The term **“Trust Agreement”** or **“Trust”** means the Trust Agreement establishing the U.A. 350 Health, Welfare, and Vacation Trust Fund, and any modification, amendment, extension or renewal thereof.

**“Trustees”** shall mean any person(s) designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such person from time to time in office. The term **“Board of Trustees”** and **“Board”** means the Board of Trustees established by the Trust Agreement.

The term **“Union”** means U.A. Local 350.

**“Urgent Care Center”** shall mean a facility that meets all licensing and other legal requirements, and all of the following:

- (a) while it may provide routine medical management, it mainly provides urgent or Emergency medical treatment for acute conditions;
- (b) it does not provide accommodations for overnight stays; it is open to receive patients each day of the calendar year;
- (c) it has on duty at all times a Physician trained in Emergency medicine, and nurses and other supporting personnel who are specially trained in Emergency care; it has x-ray and laboratory diagnostic facilities and Emergency equipment, trays and supplies for use in life-threatening events; and
- (d) it has a written agreement with a local acute care Hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care Hospitals that are immediate and reliable.

## **ARTICLE VI: PRESCRIPTION DRUG BENEFITS**

Prescription Drug benefits described in this Article are available to eligible Retirees and their eligible Dependent Spouse. Prescription drugs are provided directly by the Trust through a contract with Optum RX, Inc. More information about your prescription drug coverage is available at [www.optumrx.com](http://www.optumrx.com) or 1-800-797-9791.

### **SECTION 6.01 – DEFINITIONS.**

- a. **“Prescription Drug”** or **“Drug”** means any article which may be lawfully dispensed as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written prescription of a Physician licensed by law to administer it.
- b. **“Covered Expenses”** means the following expenses:
- (1) Pharmaceuticals legally requiring a written prescription, executed by a Physician and dispensed by a Pharmacist or by a hospital pharmacy for take-home prescriptions not otherwise covered by the Fund's plan providing medical benefits.
  - (2) Insulin and diabetic supplies and injection kits (prescription not required).
  - (3) Compounded dermatological preparations such as ointments and lotion is which must be prepared by a Pharmacist according to a Physician's prescription.



- (4) Therapeutic vitamins, cough mixtures, anti-acids, eye and ear medications prescribed by a Physician to be used in the treatment of a specific illness or complaint.
- (5) Prescriptions dispensed by a Physician for which a separate charge is made and which are to be self-administered, except with respect to allergens and antigens (other than sublingual antigens).
- (6) Prescription receipts must be submitted within 90 days of purchase.

**SECTION 6.02 – LIMITATIONS ON SUPPLY.**

- a. **Retail.** The maximum supply is 34 days of a Covered Drug except up to 100 tablets will be allowed for natural and synthetic thyroid, Phenobarbital, nitroglycerin, oral anti-diabetic drugs, digitals and its derivatives. The maximum supply is 30 days for Specialty Drug and must pay discounted price at the time of purchase.
- b. **Mail Order.** Prescription mail order coverage will cover up to a 90-day supply except will cover up to 30-day supply for Specialty Drugs.

**SECTION 6.03 – DEDUCTIBLE.** The deductible is the out-of-pocket expenses applicable to the initial purchase of any prescription and to each refill of that prescription. There is no deductible for prescriptions.

**SECTION 6.04 – COINSURANCE PAYABLE.** After the deductible has been satisfied, the fund shall pay the following percentage of Covered Expenses:

<i>Contract Provider:</i>	<i>100% of the negotiated rates</i>
<i>Non-Contract Provider:</i>	<i>100% of the Scheduled Allowance shown in Appendix A</i>

**SECTION 6.05 – EXCLUSIONS AND LIMITATIONS.** No benefits are payable for any of the following:

- a. Obtained without a prescription, except as described in 6.01b.(2).
- b. Prescriptions dispensed by a hospital, Skilled Nursing Facility or similar institution during confinement, or any other prescription charges covered under other benefits of the Medical Plan.
- c. Appliances, supports and prosthetic devices such as, but not limited to, canes, crutches, wheelchairs, or any means of conveyance or locomotion prescribed for an ambulatory patient; bandages, braces, splints, dressings or heat devices.
- d. Vitamins that may be purchased with or without a Physician's prescription, cosmetics, and food or dietary supplements.
- e. Services or materials for which a Participant may be compensated under any Workers' Compensation law or other employers' liability laws, regardless of jurisdiction; or services or materials which can be obtained without cost from any federal, state, county or local organization or agency.
- f. Any charge for an immunization agent, biological serum, blood or blood plasma.
- g. Any refills of a prescription over the number of refills specified by the Physician; any drug dispensed more than one year after the date of the Physician's prescription;
- h. Drugs prescribed for any goal-oriented behavior modification therapy such as to quit smoking, lose weight or control pain;
- i. Expenses for Experimental procedures, drugs or research studies, or for any services or supplies not considered legal in the United States;
- j. Drugs dispensed for the treatment of infertility;
- k. Drugs for cosmetic indications; health and beauty aids; drugs to promote or retard hair growth; appetite stimulants and suppressants;
- l. Any filling or refilling of prescriptions in excess of the limitations on supply in Section 6.02 or a prescription for drugs, which the Plan or its designee determines is an unreasonable supply.

**SECTION 6.06 – PLAN MAXIMUM.** There is an Annual Plan maximum of \$5,000 per retiree and an additional \$5,000 per Dependent Spouse. This \$5,000 limit applies to all covered health care expenses, including prescription drugs.

**SECTION 6.07 – PRESCRIPTION DRUGS COVERAGE WHILE ON MEDICARE.** When Medicare Part D was first created in 2006, it was primarily focused on those who had no other coverage for their prescription drug needs. You can obtain this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Coverage that is, on average, as good as or better than Medicare Part D is known as “creditable coverage.” Thus, Medicare-eligible individuals who already have creditable coverage do not have to enroll in Part D. **The Board of Trustees has determined that the prescription drug coverage offered by the Plan, is no average for all retired participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, and therefore is considered Non-Creditable Coverage. Because prescription drug coverage with the Plan is not considered creditable coverage, you might consider enrolling in a Medicare Prescription Drug Plan.**

Every year the Board of Trustees will review whether the Plan’s coverage is creditable or not creditable. The Plan will send you a Notice each year telling you whether your coverage is “creditable coverage” or “not creditable coverage.” In some cases, retirees with very limited incomes and resources may be eligible for significantly lower premiums and prescription drug Co-payments under Medicare Part D. In these situations, you may wish to consider whether this subsidized Medicare Part D coverage is a good idea for you. If you wish to find out whether you are eligible for these benefits, contact the Social Security Administration at 1-800-772-1213 or visit the Social Security web site at [www.socialsecurity.gov](http://www.socialsecurity.gov).

## **ARTICLE VII: GENERAL PROVISIONS**

**SECTION 7.01 - NO ASSIGNMENT OF BENEFITS.** The benefits payable hereunder shall not be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge or garnishment.

**SECTION 7.02 - TIME TO FILE CLAIMS.** Benefits shall be paid by the Plan only if notice of a claim is made within one hundred eighty (180) days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as required by the Board of Trustees. Any submission of claims later than one hundred and eighty (180) days are subject to the approval of the Board of Trustees, but in no event shall claims be considered for payment later than twelve (12) months from the date on which covered charges were incurred.

**SECTION 7.03 - INCOMPETENCE OR INCAPACITY.** If the Plan determines that the Covered Person is incompetent or incapable of executing a valid receipt with no appointed guardian, or in the event the Covered Person has not provided the Plan with a current address the Plan may pay any amounts otherwise payable to the Covered Person to the Covered Person’s spouse, blood relative, or any other person or institution determined to be equitably entitled to payment. In the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with this provision shall discharge the Plan and the Trustees hereunder to the extent of such payment.

**SECTION 7.04 - NO RIGHT TO BENEFITS.** No Covered Person or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereto shall be resolved by the Board of Trustees. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees. No such action may be brought unless brought within one year after date of such decision. The decision of the Board of Trustees shall be final and binding on all parties.

**SECTION 7.05 - WORKERS COMPENSATION INSURANCE.** The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation. Workers compensation is a state fund to which your employer contributes and which pays for work-related injuries or illnesses. Worker's Compensation laws vary from state to state. To obtain information, call your state bureau of worker's compensation or a local office.

**SECTION 7.06 - CONTROL DOCUMENTS.** The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

**SECTION 7.07 - AVAILABLE ASSETS FOR BENEFITS.** The benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as stipulated in the Collective Bargaining Agreement. In the event that the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer to make benefit payments or contributions (other than the contributions for which the contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

**SECTION 7.08 - FUND PHYSICIAN.** The Fund, at its own expense, shall have the right and opportunity to have a physician of its choice examine the Covered Person when and as often as it may reasonably require to resolve any claim at issue.

**SECTION 7.09 - TRUSTEE RIGHTS.** To carry out its obligation to maintain, within the limits of the funds available, a sound economic program dedicated to providing the benefits for Covered Persons, the Board of Trustees expressly reserves the right, in its sole discretion:

1. To terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects the claims in process and/or expenses already incurred;  
or
2. To alter or postpone the method of payment of any benefit; or
3. To amend any provision of this Plan Document.

**SECTION 7.10 - THIRD PARTY RECOVERY/SUBROGATION/REIMBURSEMENT.** If the Covered Person (Participant or Spouse) is injured through the act or omission (inaction) of another party, Plan benefits are available provided:

1. This Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party. You are required to notify the Plan Office if any claims you and/or your spouse incur under the Plan are the result of an accident, injury, disease or other condition for which a third party is OR MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

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

2. The Covered Person agrees to pay to the Plan immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family insurance coverage) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Covered Person who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party to the extent of the payments made by the Plan. The Plan may require that any Covered Person execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds. The Participant is liable for any amounts not paid by a spouse or child or other covered person.
3. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Covered Person against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

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

4. If the Covered Person settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust. **The Plan may offset any future claims incurred by the Participant and/or his or her family members against amounts owed to the Plan.**

**SECTION 7.11 – ERISA.** The Plan of benefits created herein is an "Employee Welfare Plan" under the Employee Retirement Income Security Act of 1974 as amended.

**SECTION 7.12 – HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 [HIPAA].** The federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that the Plan periodically remind you of your right to receive the Plan's HIPAA Privacy Notice. The Plan is very conscious of its responsibility to protect the privacy of your health care information. The Plan's Privacy Policy restricts access to your personal health care information to only those individuals or entities having a right to the information. You can request a copy of the Privacy Notice by contacting the Plan office.

**SECTION 7.13 — THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT.** Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96

hours following a cesarean delivery. Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**SECTION 7.14 – THE WOMEN'S HEALTH AND CANCER RIGHTS ACT.** Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction to achieve symmetry between the breasts;
- Prostheses, and
- Complications resulting from a mastectomy (including lymphedema).

**SECTION 7.15 – CLAIM FORMS.** All claims for benefits shall be filed on forms provided by the Plan, which will be available from the Plan Office. The Plan, upon receipt of a written notice of claim, will furnish such forms to the claimants.

**SECTION 7.16 – PROOF OF LOSS.** Written proof of loss must be furnished to the Plan for any claim of benefits payable under the Plan, other than Death or Prescription Drug Benefit, within 180 days after the beginning date of such loss. A proof of loss shall be considered to have been furnished as soon as a claim is received at the Plan Office, provided the claim is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as possible of what is necessary to complete the claim. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if the Trustees determine it was not reasonably possible to give proof within such time, provided, except in the absence of the claimant's legal capacity, it is later than one year from the time proof is otherwise required.

**SECTION 7.17 – PAYMENT OF CLAIMS.** Subject to any written direction of the Participant in an application or otherwise, all or a portion of any benefits provided by the Plan on account of hospital, medical or surgical services may, at the Plan's option, and unless the claimant requests otherwise in writing, no later than the time for filing proof of such loss, be paid directly to the Hospital or individual rendering such services. Amounts payable for other than Death Benefits will be paid to the claimant subject to the provisions set forth in this section, or if the claimant is deceased, to the claimant's beneficiary.

**SECTION 7.18 – PHYSICAL EXAMINATION.** The Plan, at its own expense, has the right and opportunity to have a physician or provider of its choice examine the person of any individual whose injury or sickness is the basis of a claim, when and as often as it may reasonably require during the continuance of a claim under the Plan.

**SECTION 7.19 – CONSTRUCTION.** The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

**SECTION 7.20 – NO VESTED RIGHT.** Nothing in this Plan shall be construed as giving Employees, retired or terminated, dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time.

**SECTION 7.21 – FACILITY OF PAYMENT.** Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor or, if there is no such guardian, to such adult or adults as have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

**SECTION 7.22 – AVAILABLE ASSETS FOR BENEFITS.** Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, to such payments. No contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder beyond the obligation of the contributing Employer to make contributions as required in the collective bargaining agreement.

In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer or any U.A. Local to make benefit payments or contributions in order to provide for the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

**SECTION 7.23 – GENDER AND NUMBER.** Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

**SECTION 7.24 – OVERPAYMENTS; DUTY OF COOPERATION.** Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made. The Fund is also entitled to recover any overpayment that is erroneously made on a claim.

If an overpayment of benefits has been made to or on behalf of the participants or dependent, the Fund, at its option, may require immediate repayment in full, set-off the overpayment from current and future benefit payments, including benefit payments due on behalf of another covered family member, and/or institute legal action to collect the overpayment and related costs and attorneys fees and interest.

You and your covered dependent must provide the Fund with any information the Fund deems necessary to determine eligibility, process claims and/or implement Plan terms. Failure to provide any information requested by the Plan or its agents may result in the rejection of a claim for benefits.

If an overpayment results from misrepresentations made by or on the behalf of the recipient of the benefits, the Fund may also obtain reimbursement of interest, professional fees incurred and other damages related to that over-payment.

A claim for benefits will be rejected and the Fund will be entitled to recover money that you, your dependents or a service provider have received if a false statement or omission of a material fact was purposely made by any person in order to receive benefits. The Fund may also obtain reimbursement of interest on this money as well as professional fees incurred and other damages.

## ARTICLE VIII: COORDINATION OF BENEFITS (COB)

All benefits of this Plan are subject to Coordination of Benefits (COB) and benefits are coordinated when you and your spouse are eligible for benefits from both this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim. COB payment amounts shall not exceed the contracted maximums of the contract providers. At no time will the Plan pay more than for what the Participant is financially responsible.

**SECTION 8.01 – PURPOSE.** The intent of this Article is to guarantee that the amount of benefits paid under this Plan plus the amounts of benefits paid under all other plans shall not exceed the actual cost charged for a treatment or service.

1. **COB Claims.** Benefits are coordinated on all employee, retiree and dependent claims. COB applies only to medical and prescription drug benefits.
2. **Sharing of Information.** The Fund Office may release or receive necessary information about your claim to or from other sources. You must furnish the Fund Office with any information it needs to process your claim.
3. **Claim Filing Requirement.** You must file a claim for any benefits you are entitled to from any other source. Regardless of whether you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).
4. **Other Group Plans.** Benefits are coordinated with other group plans, including other insurers such as group Blue Cross and Blue Shield plans, motor vehicle insurance, and blanket insurance plans. If you or your spouse are covered under another plan, you can contact the Plan Office to find out whether that plan fits the definition of a group plan.
5. **Medicare.** Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A and Part B of Medicare, even if he has not actually enrolled in both Parts.
6. **File Claims with Other Plans Too.** When anyone in your family is covered under another group health plan and has a claim, be sure that you file claims with all eligible plans and provide all required information about other coverage on all claim forms.
7. **Failure to Take Action.** If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time.
8. **Auto Insurance and Other Policies.** In the event a covered person is eligible for benefits under this Plan as well as under other group or individual fault or no-fault automobile insurance policies, this Plan's benefits will coordinate with those under the automobile insurance policies, so that the total benefits be paid under all policies do not exceed 100% of the total allowable expenses actually incurred.

In all cases where a covered person is eligible for receipt of benefits under a no-fault automobile insurance policy, the automobile insurance carrier will be primary.

### **SECTION 8.02 – DEFINITIONS.**

1. **COORDINATION** - shall mean benefits are paid so that no more than 100% of the Network Allowance shall be covered under the combined benefits from all of the plans shown in paragraph 2 below.
2. **PLAN** - shall mean any medical expense benefits provided under:
  - a. any insured or non-insured group, service, prepayment, or other program arranged through an Employer, Trustee, union, or association; or
  - b. any program required or established by state or federal law (including Medicare Parts A and B); or
  - c. any program sponsored by or arranged through a school or other educational agency; and the first party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent or any minimum benefits required by law except that the term Plan shall not include benefits provided under a student accident policy or any individual policy, nor shall the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

The term Plan shall apply separately to those parts of any program that contain provisions for coordination of benefits with other plans and separately to those parts of any program that do not contain such provisions.

3. **ALLOWABLE EXPENSE** - shall mean all Prevailing Charges for treatment or service when at least a part of those charges are covered under at least one of the Plans then in force for the Covered Person for whom benefits are claimed.
4. **CLAIM DETERMINATION PERIOD** - shall mean the part of a calendar year during which a Covered Person would receive benefit payments under this Plan if this Article were not in force.

**SECTION 8.03 - EFFECT ON BENEFITS.** Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period shall be reduced if:

1. Benefits are payable under any other Plan for the same Allowable Expenses; and
2. The rules listed in Section 10.04 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction shall be the amount needed to provide that the sum of payments under this plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this Article shall be reduced proportionately; any such reduced amount shall be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans shall include the benefits that would have been paid had claim been made for them. Also, for any person covered by Medicare Part A, benefits payable shall include benefits provided by Medicare Part B, whether or not the person is covered under that Part B.

**SECTION 8.04 - ORDER OF BENEFIT DETERMINATION.** Benefits payable from a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this Article are determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination shall be:



1. EMPLOYEE vs. DEPENDENT / PRIMARY vs. SECONDARY. The benefits of a Plan that cover the person for whom benefits are claimed as an Employee (other than as a Dependent) are determined before the benefits of a Plan that cover the person as a Dependent.
2. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.
3. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person (for whom the claim is filed) for the longest period will pay first.
4. DEPENDENTS OF DECEASED RETIREE. This Plan shall always pay secondary to any other group type coverage.
5. GOVERNMENTAL PROGRAM. If there is coverage by a governmental program, the governmental program has primary responsibility unless prohibited by federal law.

#### **SECTION 8.05 – COORDINATE WITH MEDICARE.**

1. RETIREES (AND THEIR SPOUSES) ELIGIBLE FOR MEDICARE. If you are an eligible retiree, and if you and/or your spouse are eligible for Medicare and have enrolled in both Medicare Part A and Part B, this Plan will coordinate benefits with Medicare on your claims. This means that Medicare will pay first, and this Plan will pay (up to a lifetime maximum of \$5,000) after Medicare pays, based on amounts not paid by Medicare. The Plan will determine its benefits as the secondary payor based on the amount of the charge allowed by Medicare—it will not pay any amount in excess of Medicare's allowable charge.

If you have not enrolled in Medicare Parts A and B, this Plan will calculate its benefits as if you had. This means that this Plan will only pay benefits equal to the benefits it would have paid if you were enrolled in both Parts, unless a different payment is required by law. You will have to pay the amount normally paid by Medicare.

Medicare-eligible retirees (and Medicare-eligible spouses of retirees) have the option of dropping this Plan's prescription drug coverage and switching to a Medicare Part D plan.

2. SPOUSE HAS OTHER COVERAGE AND ELIGIBLE FOR MEDICARE. If your spouse has coverage as an active employee through his/her health plan and also has Medicare coverage, your spouse's health plan will be the primary payer of eligible health care expenses, Medicare would be the secondary payer, and this Plan would be the third payer (up to a lifetime maximum of \$5,000).
3. ALL MEDICARE-ELIGIBLES AGE 65 OR OVER. Persons age 65 or older are also entitled to select Medicare as their coverage. To do so, they must decline all coverage under this Plan. Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

**SECTION 8.06 - EXCHANGE OF INFORMATION.** Any Covered Person who claims benefits under this Plan shall, upon request, provide all information the Trust believes is needed to coordinate benefits as described in this Article. All information the Trust believes is needed to coordinate benefits shall be exchanged with other plans, companies, organizations, or persons.

**SECTION 8.07 - FACILITY OF PAYMENT.** The Trust may reimburse any other Plan if benefits were paid by that other Plan, but should have been paid under this Plan in accordance with this Article. In such event, the reimbursement amounts shall be considered benefits paid under this Plan and, to the extent of those payments, shall discharge the Trust from liability.

## **ARTICLE IX: CLAIMS AND APPEAL PROCEDURE**

The following procedures apply to the Eligibility Provisions and Indemnity Plan Benefits included in this booklet.

### **A. HOW TO FILE A CLAIM**

Claims are paid in accordance with bills and forms supplied by hospitals and attending physicians. A claim shall be considered to have been filed as soon as it is received by the Plan Office at its principal office, provided it is substantially complete, with all necessary documentation. When filing a claim for benefits, be sure to complete all of the required information. This includes the name of your spouse's employer and the identification of any other group insurance plan. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim. Claims must be filed within 12 months from the date of treatment. Have your Physician forward claims directly to the Plan Office.

Retiree members and their dependents that are eligible for Medicare should have the hospital and doctors submit claims to Medicare first. After Medicare has made a payment, a copy of the Medicare Explanation of Benefits Worksheet should then be submitted with a claim to the Plan Office for processing.

### **B. CLAIMS AND APPEALS PROCEDURES**

#### **1. DEFINITIONS.**

a) **Adverse Benefit Determination.** An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

- (1) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);
- (2) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;
- (3) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not Medically Appropriate;
- (4) a restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and
- (5) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

b) **Claim.** The term "Claim" means a request for a benefit made by a Participant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for precertification or prior authorization of a benefit that does not require precertification or prior authorization by the Plan is not considered a Claim. However, requests for precertification or prior authorization of a benefit where the Plan does require precertification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

Claims are categorized as Follows:

(1) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(2) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(3) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

(4) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for reimbursement for services already rendered.

(5) Disability Claims. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

c) Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

## 2. NOTICE OF CLAIM DENIAL

If a claim is wholly or partially denied, the claimant shall receive a written notice of denial as follows:

a) Contents of Notice: The notice of denial shall contain the following, written in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the denial;
- (2) Specific reference to pertinent Plan provisions on which the denial is based;
- (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
- (4) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

**b) Time of Notice:** To assure that you are eligible for medical or hospital benefits, you should call or have your physician /hospital call the Plan Office to pre-certify your eligibility for benefits. In the event that you do not obtain precertification and the Plan Office determines that a claim is not covered for any reason, you will be notified of a claim denial:

**c) Urgent Care:** In the event the claim involves “urgent care,” which is defined as any claim for medical care or treatment which in your physician’s opinion is required immediately to avoid jeopardizing your life, health or ability to regain maximum function, you will be notified within twenty-four (24) hours of the submission of the claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours in the event coverage is denied.

**d) Pre-Service Claims.** A Pre-Service Claim is a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained as a condition of receiving maximum benefits allowed under the Plan. Under the terms of this Plan, claimants are not required to obtain precertification for any services.

**e) Concurrent Claims.** Any request by a Participant to extend an approved Urgent Claim will be acted upon by the Plan within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a Plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

**f) Post-Service Claims.** A Post-Service Claim must be submitted to the Plan Office in writing, using an appropriate claim form, as soon as possible after expenses are incurred. A claim form may be obtained by contacting the Plan Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time; however, in that case, the Claim must be submitted as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include any information requested by the Plan Office.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Plan Office.

Ordinarily, Participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Plan Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Participant will be notified, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the Participant, the Plan will issue a Request for Additional Information that specifies the information needed. The Participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is, suspended from the date of the Request for Additional Information until either 45 days or until the date the Participant responds to the request, whichever is earlier. The Plan then has 15 days to make a decision on the Claim and notify the Participant of the determination.

If the Plan determines that additional information is required from the Participant, and the Participant fails to provide any requested information within 45 days, the Plan will issue a Notice of Adverse Benefit Determination.

**g) Disability Claim.** A Disability Claim must be submitted to the Plan Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the Participant of the decision within 45 days after receipt of the Claim by the Plan Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Plan Office will notify Participant of the reason for the delay and the date by which the Plan expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the time the Plan notifies the Participant of the delay. The period for making a decision may be delayed an additional 30 days, provided the Plan notifies the Participant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Participant responds to the request. Once the Participant responds to the Plan's request for the information, the Participant will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

**h) Authorized Representatives.** An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a Participant if the Participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative form, which may be obtained from the Plan Office, must be used to designate an authorized representative. The Plan Office may request additional information to verify that the designated person is authorized to act on the Participant's behalf.

A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete the Appointment of Authorized Representative form.

### 3. **APPEAL PROCEDURES.**

a. **Appealing an Adverse Benefit Determination.** If a Claim is denied in whole or in part, or if the Participant disagrees with the decision made on a Claim, the Participant may appeal the decision. Appeals must be made in writing and must be submitted to the Plan Office within 180 days after the Participant receives the notice of Adverse Benefit Determination.

(1) **Urgent Claims.** Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made within 180 days after receipt of the Notice of Adverse Benefit Determination by either:

- a. Calling the Plan Office and asking to speak to the Utilization Review Representative. All oral requests must be followed by a faxed written request within 24 hours.
- b. Faxing the request to the attention of the Utilization Review Representative.

Appeals of Urgent Claims may not be submitted via the US Postal service.

(2) **Concurrent Claims.** Appeals of Adverse Benefit Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(3) **Post-Service and Disability Claims.** The appeal of a Post-Service or Disability Claim must be submitted in writing to the Plan Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

- a. the patient's name and address;
- b. the Participant's name and address, if different;
- c. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;
- d. the date of the Adverse Benefit Determination; and the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

b. **The Appeal Process.** The Participant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The Participant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the Participant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the Participant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

c. **Time Frames for Sending Notices of Appeal Determinations.**

(1) **Urgent Claims.** Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Plan Office.

(2) **Concurrent Claims**. Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Plan Office.

(3) **Post-Service and Disability Claims**. Ordinarily, decisions on appeals involving Post Service and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of Participant's request for review. However, if the request for review is received at the Plan Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the Participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Participant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of Participant's Claim has been reached, the Participant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

If the decision on review is not furnished to the Participant within the time specified in this Subsection (C), Participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his or her Claim in accordance with Subsection e, below.

**d. Content of Appeal Determination Notices**. The determination of an appeal will be provided to the claimant in writing. The notice of a denial of an appeal will include:

- (1) the specific reason(s) for the determination;
- (2) reference to the specific Plan provision(s) on which the determination is based;
- (3) a statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
- (4) a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal;
- (5) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and
- (6) if the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

**e. Trustee Interpretation, Authority and Right**. The Board of Trustees has full authority to interpret the Plan, all Plan documents, rules and procedures. Their interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Parties to whom the Trustees have delegated the right of decision-making may also have the discretion to interpret the Plan. If a decision of the Trustees, or a party to whom the Trustees have delegated decision-making authority, is challenged in court, it is the intention of the parties that such decision is to be upheld unless it is determined to be arbitrary or capricious.

Benefits under this Plan will be paid only when the Board of Trustees, or persons delegated by them to make such decisions, decide, in their sole discretion, that the participant or beneficiary is entitled to benefits under the terms of the Plan.

The Trustees have the authority to amend the Plan, which includes the authority to change eligibility rules and other provisions of the Plan, and to increase, decrease or eliminate benefits. In addition, the Trustees may terminate the Trust and this Plan of Benefits at any time. All benefits of the Plan are conditional and subject to the Trustees' authority to change or terminate them. The Trustees may adopt such rules as they feel are necessary, desirable or appropriate, and they may change these rules and procedures at any time.

The Trustees specifically have the right and the authority to change the provisions relating to coverage for retirees and their dependent at any time and in their sole discretion, since the Retiree Benefits are not “accrued” or “vested” benefits. Any such change made by the Trustees will be effective even though employee has already become a covered retiree.

The Trustees intend that the Plan terms, including those relating to coverage and benefits, are legally enforceable and that the Plan is maintained for the exclusive benefit of the participant and beneficiaries.

**f. When a Lawsuit may be Started – One Year.** No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

**No lawsuit may be started more than one year after the date on which medical or prescription services were provided,** or, if the Claim is for short term disability benefits, more than one year after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a Plan "Participant" or "beneficiary" within the meaning of those terms as defined in ERISA.

## **ARTICLE X: POTENTIAL LOSS OF BENEFITS**

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

- A. Exclusions/Co-Payments.** The various plans and insurance policies contain exclusions that may preclude you from having coverage. You are also responsible for co-payments in most situations.
- B. Ineligible.** The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.
- C. Not Timely.** The claim wasn't filed within the Plan time limits.
- D. Not Covered or Not Incurred.** The expenses that were denied are not covered under the Plan or were not actually incurred.
- E. Full Benefit Provided.** The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.
- F. Plan Change.** The Trustees amended the Plan's eligibility rules or decreased Plan benefits.
- G. Recover Overpayment.** The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf or on behalf of another member of the same family.
- H. Fail to File Complete Application** Benefits may not be payable until a completed application and other required forms and information is received by the Plan Office.



**I. Incomplete Information/False Statements.** If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Plan Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

**J. Inadequate or Improper Evidence.** The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Plan Office any information or proof or coverage reasonably required to administer the Plan.

**K. Subrogation/Third Party Claims.** The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

**L. Coordination of Benefits.** If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

**M. Work-Related Injuries.** The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you have not filed a claim with workers compensation.

**N. Failure to Enroll in Medicare Parts A and B.** If you are eligible for and fail to enroll in Medicare parts A and B, the Plan will not pay many of your claims.

**O. Right to Recover Claims Paid or Offset of Future Claims.** The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

**P. Prohibited Employment in the Plumbers and Pipefitters.** If you engage in certain kinds of work in the Plumbing and Pipefitters, known as Prohibited Employment, you will no longer be entitled to Retiree Health and Welfare benefits.

**Q. Plan Termination.** If the Plan terminates, benefits may no longer be provided.

**The preceding list is not an all-inclusive listing of the circumstances that may result in denial or loss or delayed payment of benefits. It is only representative of the types of circumstances, in addition to failure to meet the regular eligibility requirements that might cause denial of a claim for benefits. If you have any questions about a claim denial, contact the Fund Manager.**

## **ARTICLE XI: AMENDMENT/TERMINATION/MERGER OF PLAN**

### **A. AMENDMENT OF PLAN**

The Board of Trustees has the discretion to amend the Plan at any time. Moreover, if the Collective Bargaining Agreement is amended by the insertion or deletion of provisions relating to the Plan, the Board of Trustees will amend the Plan to effectuate the intent of the amendment to the Collective Bargaining Agreement, unless such amendment conflicts with applicable law or is actuarially unsound.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA. Except as is permitted or required by applicable law, no amendment may divest any accrued benefits which have previously been vested.

**B. TERMINATION OF PLAN**

It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan and to state the rights of the Participants in such an unlikely event.

The parties to the Collective Bargaining Agreements between U.A. Local 350 and the Employer associations may terminate the Plan in whole or in part. Although there is no intent to terminate the Plan, there is no guarantee that the Plan will last forever.

**C. MERGER OR CONSOLIDATION**

In the event of a merger or consolidation of the Plan with, or transfer in whole or in part, of the assets or liabilities of the Plan to any other Pension Plan, each Participant is entitled to a benefit immediately after the merger, consolidation or transfer which is at least equal to the benefit such Participant would be entitled to receive before such merger, consolidation or transfer.

**ARTICLE XII: ADDITIONAL INFORMATION REQUIRED BY ERISA**

**A. NAME AND TYPE OF PLAN**

The name of the Plan is the **U.A. Local Retiree 350 Health and Welfare Plan** ("Plan"). The Plan is tax-exempt under Section 501(c)(9) of the Internal Revenue Code.

**B. PLAN ADMINISTRATOR**

The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board is responsible for the operation and administration of the Plan, including ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Board has contracted with Benefit Plan Administrators to be the Fund Manager for the Plan. You may contact the Plan as follows:

Jim Mace, Fund Manager  
U.A. Local 350  
Health & Welfare Plan  
445 Apple Street  
P.O. Box 11337  
Reno, Nevada 89510

**C. AGENT FOR THE SERVICE OF LEGAL PROCESS**

The person designated as agent for service of legal process is:

Richard K. Grosboll & Lois H. Chang  
Neyhart, Anderson, Flynn & Grosboll  
369 Pine Street, Suite 800  
San Francisco, CA 94104-3323  
(415) 677-9440

Service of legal process may also be made upon the Fund Manager, any Plan Trustee, or the Board of Trustees, at the addresses listed on **page ii** of this booklet.

**D. PLAN YEAR**

The Plan Year commences on September 1 and ends August 31.

**E. EMPLOYER IDENTIFICATION**

The Internal Revenue Service Employer Identification Number (EIN) for this Plan is 81-0754804.

**F. FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS**

The Plan is maintained in accordance with Collective Bargaining Agreements between the U.A. Local 350 and certain designated Employer associations (and some individual Employers), which require Employers to contribute to the Plan.

The Plan Office will provide you upon written request with information on whether a particular Employer for whom you work is contributing to the Plan and if the Employer is a contributor, the Employer's address.

**G. FUND MEDIUM**

Assets of the Plan are held in Trust.

## **STATEMENT OF ERISA RIGHTS**

As a Participant in the U.A. Local 350 Retiree Health and Welfare Plan ("Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Participants are entitled to:

### **RIGHT TO RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS**

- Examine without charge at the Plan Office and at other specified locations such as worksites and the Union office, documents governing the Plan, including Collective Bargaining Agreements and the latest annual report (Form 5500 series) filed with the Department of Labor (and which is available at the Public Disclosure room of the Department of Labor's Employee Benefits Security Administration ("EBSA") office.
- Obtain copies of Plan documents governing the Plan (those documents that are required by law to be furnished) upon written request to the Plan. Pursuant to ERISA, the Plan Office may require that you pay a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with the SAR.

### **PRUDENT ACTIONS BY PLAN FIDUCIARIES**

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for operating the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person or entity, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

### **ENFORCING YOUR RIGHTS UNDER ERISA**

If your claim for a benefit is denied in whole or in part, you will receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$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, and which is upheld on appeal (or ignored), you may file a lawsuit. **Under the Plan, you are required to file a lawsuit within one year after your appeal has been denied.** In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or other assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

If you file a lawsuit, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person(s) you have sued to pay your costs and fees. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees (e.g., your claim was frivolous).

## **ASSISTANCE WITH YOUR QUESTIONS**

If you have any questions about your Plan, you should contact the Plan Office.

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 Employee Benefits Security Administration (EBSA), U.S. Department of Labor at EBSA's toll free number at 866-444-3272 or writing to the Department's national office at the following address:

Division of Technical Assistance and Inquiries  
U.S. Department of Labor  
Employee Benefits Security Administration  
200 Constitution Avenue NW  
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-866-444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions at: <http://www.dol.gov/ebsa/welcome.html>.

## **ADOPTION BY THE BOARD OF TRUSTEES**

**IN WITNESS WHEREOF**, the Trustees have caused this Plan to be restated and adopted as of September 1, 2014.

**U.A. LOCAL 350 RETIREE HEALTH & WELFARE PLAN**