U.A. LOCAL 350
HEALTH, WELFARE AND VACATION TRUST FUND
P.O. Box 1037 • Sparks, Nevada 89432 • 1110 Greg Street • Sparks, Nevada 89431
Telephone: (775) 359-6387 • Fax: (775) 359-6783

May 2016

To: **All Participants**

From: **Board of Trustees, U.A. Local 350 Health, Welfare and Vacation Plan**

Re: **Important Notice About Your Prescription Drug Coverage and Medicare**

This Notice is for participants with Medicare. If you or any of your eligible family members are now eligible for Medicare or will become eligible for Medicare in the next 12 months, please read this notice carefully and keep it where you can find it. If, however, you and/ or your family members are not currently eligible for Medicare and will not be eligible during 2017 you may disregard this Notice.

This Notice has information about your current prescription drug coverage with the U.A. Local 350 Health, Welfare and Vacation Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the Plan offering Medicare prescription drug coverage in your area. Information on where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. 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. Some plans may also offer more coverage for a higher monthly premium.

2. The Board of Trustees of the U.A. Local 350 Health, Welfare and Vacation Trust Fund has determined that the prescription drug coverage offered by the Health Plan is, on average for all Plan Participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is therefore considered "Creditable Coverage."

Because your existing prescription drug coverage is, on average, for all Plan Participants, at least as good as standard Medicare prescription drug coverage, you can keep your prescription drug coverage under the U.A. Local 350 Health, Welfare and Vacation Plan and you do not need to enroll in a Medicare prescription drug program. You will not have to pay any extra premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year thereafter from October 15th through December 7th. If, however, you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

YOUR CHOICES:

1. **You can keep your current prescription drug coverage with the U.A. Local 350 Health, Welfare and Vacation Plan and you do not have to enroll in a Medicare prescription drug plan.**

   - You may in the future enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (October 15th through December 7th of each year). You will not be charged any penalty if you later decide to purchase a Medicare prescription drug plan.

2. **You can keep your current prescription drug coverage with U.A. Local 350 Health, Welfare and Vacation Plan and enroll in ONE Medicare prescription drug plan as a supplement to the coverage under the Plan. (You will have to pay a premium to enroll).**

   - If you do this, the U.A. Local 350 Health, Welfare and Vacation Plan will pay primary to Medicare for you and any dependent(s) that you cover, even if you or your dependent also has Medicare. However, a dependent spouse's plan will pay primary if the dependent spouse is covered under their own plan. You will need to pay the part D premium out of your own pocket. You should determine whether the amount of this Part D Premium is worth the cost based on the likely benefits that you would receive. For more information on the monthly Part D premium being charged, please visit *http://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html.*

   - Your current coverage with U.A. Local 350 Health, Welfare, and Vacation Plan pays for other health expenses in addition to your prescription drug. If you enroll in one Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

   - If you do decide to join a Medicare prescription drug plan and drop your current coverage with the Plan, be aware that you and your dependents will not be able to get this coverage back.

What Will Happen If You Lose or Drop Coverage With the U.A. Local 350 Health, Welfare and Vacation Plan And Do Not Enroll In a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the U.A. Local 350 Health, Welfare and Vacation Plan and do not enroll in a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice or your current prescription drug coverage

For further information, contact the U.A. Local 350 Health, Welfare and Vacation Trust Fund Office, P.O. Box 11337, Reno, NV 89510; phone 775-826-7200.

NOTE: You will receive this notice annually. You will also receive this notice before the next period you can join a Medicare prescription drug plan, and if the coverage provided by this Plan changes or terminates. You also may request a copy of this Notice at any time.

Creditable Prescription Drug Coverage

The UA Local 350 Health, Welfare, and Vacation Plan provides prescription drug coverage through contract with Optum RX, Inc. For more information about prescription drug coverage, visit www.optumrx.com or call 1-800-797-9791.

	Contract Provider	Non-Contract Provider
Generic	Retail ($10 copay)/Mail order ($10 per month)	Retail (After $10 copay plus non-covered charge)/ Mail Order (Not Covered)
Brand	Retail ($10 copay)/Mail order ($10 per month)	Retail (After $10 copay plus non-covered charge)/ Mail Order (Not Covered)
Specialty	Retail ($10 copay)/Mail order ($10 per month)	Not Covered
Deductible/Annual Limit	$10 Per Prescription Drug/No Annual Limit.	

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. All persons enrolled in Medicare (a "beneficiary") will receive the handbook in the mail each year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug plans:

- Visit *www.medicare.gov*
- Call your State Health Insurance Assistance Program (see the inside back cover of the "Medicare & You" Handbook for the telephone number) for personalized help or visit: *https://www.medicare.gov/contacts/#resources/ships*.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA) online at *www.socialsecurity.gov*, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: KEEP THIS CREDITABLE COVERAGE NOTICE. If you decide to enroll in one of the new Medicare approved prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	May 2016
Name of Entity/ Sender:	U.A. Local 350 Health, Welfare and Vacation Trust Fund
Contact/Position/Office:	James G. Mace, Fund Manager Benefit Department
Address:	445 Apple Street, Ste. 109, Reno, Nevada 89502
Phone:	(775) 826-7200

As in all cases and situations, U.A. Local 350 Health, Welfare and Vacation Plan reserves the right to modify benefits at any time, in accordance with applicable law. As required by law, this document is intended to serve as your Medicare Notice of Creditable Coverage.

U.A. LOCAL 350 HEALTH & WELFARE PLAN

445 APPLE STREET * P.O. BOX 11337 * RENO, NV 89510 * P. (775) 826-7200 F. 775) 824-5080

May 2016

Dear Members,

This Notice includes annual notices the Plan is required to provide you under the Affordable Care Act and other Federal Laws. It also includes other reminders. This is for informational purposes only. No action is necessary.

Grandfathered Health Plan Reminder

The Board of Trustees believes that the U.A. Local 350 Health and Welfare Plan is a "grandfathered health plan" under the Affordable Care Act ("ACA"). As permitted by the Affordable Care ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that ACA was enacted. Being a grandfathered health plan means that your Plan is not required to include certain consumer protections of the ACA that apply to other plans (known as a Non-Grandfathered plan), for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the Act, such as the elimination of annual and lifetime limits on Plan benefits.

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

Women's Health and Cancer Rights Act

Do you know that your 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, reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of physical complications resulting from all stages of the mastectomy, including lymphedema (swelling that sometimes happens after treatment for breast cancer). This coverage may be subject to the Plan's deductibles, coinsurance, and co-payment provisions (consistent with those established for other benefits under the Plan). If you have any questions, please call the Plan administrator at 775-826-7200.

Newborns and Mothers Health Protection Act

Under Federal law, Group Health Plans and Insurers, may not generally restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours). The Plan and Insurers may not set level of benefits or out-of-pocket costs so that any portion of the 48-hour (96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the Plan and Insurers cannot require that a physician or health care provider obtain authorization for prescribing a length of stay up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs you may be required to obtain precertification. Call the Plan administrator at 775-826-7200 for more information.

HIPAA Privacy Notice Reminder

This Notice is to remind you that, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Plan will only use or disclose your individual health information, known as protected health information, in accordance with the Plan's Notice of Privacy Practices. You may obtain a copy of the Plan's Notice of Privacy Practices at any time by calling the Plan Administrator at 775-826-7200, to request that a copy be mailed to you. Within a reasonable period of time of your request, the Plan administrator's office will mail you a copy of the Notice. The Notice is also automatically provided to you at least once every three years or when there is a material change to the Notice.

Calendar Year Deductible Reminder

The Plan's Calendar Year deductibles are $250 per individual and $750 per family. Three individual deductibles met in full by three family members during a calendar year will satisfy the family deductible maximum for that particular calendar year. The Deductible is the amount of covered expenses you and/or your family must pay during each calendar year before major medical benefits are payable by the Plan. NOTE: Please further be advised, the calendar year deductible is not waived when there is dual coverage and the Plan is secondary.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or the Children's Health Insurance Program ("CHIP") and you are eligible for health coverage from your employer, the State you reside in may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State that provides premium assistance, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **877/KIDS NOW** or ***www.insurekidsnow.gov*** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at *www.askebsa.dol.gov* or by calling toll-free 866/444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE

Under the Affordable Care Act, Group health plans are responsible for providing a Summary of Benefits Coverage, also known as an SBC, to eligible new Participants and their dependents. The SBC provides a summary of what the Plan covers and what it costs. You also have the right to request and receive within 7 business days a SBC for the Plan. If you want a copy of the Plan's SBC and/or more details about your coverage and costs, please contact the Plan at (775) 826-7200.

INDIVIDUAL MANDATE & MINIMUM ESSENTIAL COVERAGE

The Affordable Care Act establishes a minimum value standard of benefits for health plans and requires you and your dependents to have health coverage that qualifies as minimum essential coverage. Subject to certain exceptions, failure to have minimum essential health coverage will subject you to an IRS penalty. The minimum value standard is 60% (actuarial value) and eligible employer-sponsored plans (such as this Plan) are considered minimum essential coverage. As such, if you are covered under this Plan you meet the individual mandate, since the Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

RECISSION OF COVERAGE RESTRICTIONS

Under the Affordable Care Act, the Plan and Insurers cannot retroactively cancel or terminate your coverage, except in cases of fraud, intentional misrepresentation of material fact, or failure to timely pay premiums. However, a retroactive cancellation of coverage is not considered a rescission if (1) it only has prospective effect, (2) is initiated by the covered individual, (3) due to delay in administrative record-keeping, (4) attributed to a failure to timely pay required premiums or contributions toward the cost of coverage, or (5) termination of coverage retroactive to the divorce, if the Plan does not cover former spouses. Plans and Insurers that rescind coverage must give affected individuals at least 30 days advance notice.

MEDICARE COORDINATION For Retirees Who Are Eligible for Medicare – You are Required to Enroll

Medicare is our country's federal health insurance program for people who worked at least ten years in Medicare-covered employment who are age 65 or older, for people under age 65 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.

Under the Medicare program, the hospital insurance portion is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. 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. Most working people are entitled to Medicare Part A when they reach age 65 because either they or a spouse paid Medicare taxes while working.

If you are retired, the Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) and Part B (medical benefits). This means you and/or your spouse must enroll in **both Medicare Part A and Part B**, as soon as you and/or your spouse are eligible for Medicare. If you and/or your spouse 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 failure to do so will resort in late enrollment penalties.

Medicare's prescription drug plan (**Medicare Part D**) is available to Medicare beneficiaries and is part of your coverage if you are enrolled in the Plan. If you earn a higher income (above $85,000 for individuals or above $170,000 for married couples), Federal Law requires that you pay an additional premium for your Medicare Part D coverage to the Social Security Administration. This additional premium is called the Income-Related Monthly Adjustment Amount (also known as "IRMAA"). The premium is based on your modified adjusted gross income as reported on your IRS tax return from two years

ago (thus, the fee in 2016 will be based on your adjusted gross income on your 2014 tax return). If you must pay a higher premium, Medicare will send you a letter with your premium amounts and the reason for their determination.

For more information on Medicare, please call Medicare at 800/MEDICARE (800/633-4227) or visit *www.medicare.gov*. TTY users should call 877/486-2048. If you have any questions, please contact the Plan Office at (775) 826-7200.

Special Enrollment Rights

Under Federal Law, if you declined enrollment for yourself and/or your dependents because of having other sufficient group health coverage, you may be able to enroll yourself and/or your dependents in this Plan, if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents within 30 days after the birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form along with any other Plan required documentation (ex. marriage certificate, birth certificate, adoption papers) to the Trust Fund Office. To request special enrollment information, please contact the Plan Administrator at (775) 826-7200.

IMPORTANT REMINDER to provide Plan with Taxpayer Identification Number (TIN) OR Social Security Number (SSN) of Each Enrollee

Employers and Plans are required by law to collect the Taxpayer identification number (TIN) or Social Security Number (SSN) of each Plan Participant and Dependent. Employers and the Plan are required to provide that number on reports (known as the Forms 1094-B, 1095-B, 1094-C, and 1095-C) that will be provided to the IRS each year. Employers and Plans are required to make at least three attempts to gather missing TINs/SSNs.

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

If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the Plan, please contact the Plan Administrator at (775) 826-7200.

Option to Decline Dental and/or Vision Coverage

In accordance with Health Reform regulations, you have the option to decline/waive the Plan's dental and vision coverage. To decline/waive coverage complete the portion of the Plan's enrollment form related to declining/waiving dental and/or vision coverage. Enrollment forms are available from the Trust Fund Office. Note that there is no additional compensation to you if you choose to decline/waive dental and/or vision coverage. Please contact the Plan Administrator at (775) 826-7200 for more information.