SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT

RESTATED
U.A. LOCAL 350 HEALTH, WELFARE AND VACATION PLAN

(Medical, Prescription Drugs, Vision Care, Dental, Weekly Disability, Life Insurance, Accidental Death and Dismemberment Benefits for Active Participants and Dependents) Website: https://350 plumbers.com

[Vacation benefits are also provided through the Plan.]

Restated as of October 2021

Keep this Summary Plan Description and Plan Document For Future Reference.

Trust Fund Office Address: 445 Apple Street, P.O. Box 11337 Reno, Nevada 89510
T: (775) 826-7200 (Website: *https://350plumbers.com*)
Union Office Address: UA Local 350, 1110 Greg Street, Sparks, Nevada 89431
T: (775) 359-2142 (Website: *ualocal350.org*)

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Randy Canale U.A. Local 350 1110 Greg Street Sparks, NV 89432	**Michael W. Scolari** Ray Heating Products Inc. P.O. Box 2957 Reno, NV 89505
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U.A. LOCAL 350 HEALTH, WELFARE AND VACATION PLAN

445 Apple Street
P.O. Box 11337
Reno, Nevada 89510
Telephone: (775) 826-7200
Website: *https://*350plumbers.com

Dear Participant & Dependent:

The Board of Trustees is pleased to provide you this new Restated booklet. This booklet is both the Plan document and Summary Plan Description for the U.A. Local 350 Health, Welfare and Vacation Plan ("Plan"). The first part of the booklet contains general information regarding your medical and related benefits and an explanation of the eligibility provisions for both active and certain retired Participants. There is a separate booklet for retiree health and welfare benefits only. For a copy of the retiree booklet please contact the Trust Fund office. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Trust Fund Office at the above address. **This updated booklet is also being updated to the Trust Fund office website at https://350plumbers.com.**

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

This booklet also contains information about Life Insurance and Accidental Death and Dismemberment benefits provided under a contract between the Board and The Union Labor Life Insurance Company. The Plan also provides vacation benefits for eligible U.A. Local 350 members.

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

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may reduce or eliminate or change any benefits provided under the Plan (or any insurance policyor 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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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 Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement Plans. This Plan provides only limited retiree medical benefits in any event.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

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

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

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

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

NO VESTED RIGHTS

Benefits under this Plan are <u>NOT</u> 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 October 1, 2021. 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 also known as the Schedule of Allowances for its Non-PPO claims and services. As for the PPO claims and services, the Plan uses the negotiated Contract rate. Thus, the Plan does not use "Usual Customary and Reasonable", "Reasonable and Customary" or "Billed Charges".

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 36-39 of this booklet. Exclusions for your Prescription Drug Coverage are listed on Pages 47-48, for vision care on page 49, and dental benefits on pages 53-55.

D. CHART OF EMPLOYEE AND DEPENDENT BENEFITS. The following chart outlines the benefits to which Active Employees and their eligible Dependents are entitled.

BENEFIT	ELIGIBILITY	
	Active Employees	Dependents
Life Insurance	**X**	**X**
Accidental Death and Dismemberment	**X**	**X**
Basic and Major Medical Benefit	**X**	**X**
Prescription Drug Benefit	**X**	**X**
Vision Care Benefit	**X**	**X**
Dental Care Benefit	**X**	**X**

If Trust Fund benefits for you or your eligible Dependents will soon terminate, please refer to the ***COBRA CONTINUATION COVERAGE*** section beginning on page 19, which describes important information on how you may extend Medical, Prescription Drug, Vision, and Dental Benefits.

E. 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.

Under the Medicare program, the hospital insurance portion is called Medicare Part A. 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.

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 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 continued Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) 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. 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.

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) 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.

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

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

II. SCHEDULE OF MEDICAL BENEFITS

BASIC MEDICAL BENEFITS
Self Funded Benefits Provided by the Fund

Outpatient Emergency Accident Benefit – $25 copay	$100 per treatment at 100% then a For Emergency Service, then Major Medical Benefits apply
For Hospital only, treatment provided within 24 hours Outpatient Emergency	$25 Copay for Emergency Services
Voluntary Second Surgical Opinion – Prior to an elective non-Emergency Surgical Procedure	$100 per Surgical Opinion paid at 80% to a maximum of $100
Preadmission Testing Benefit	For Lab work only
Ambulance Service Benefit	$25 per accident paid at 100% then benefits is 70% of Schedule Allowance
Additional Accident Care Benefit	$300 per Accident, then Major Medical Benefits apply
Hospice Care Benefit	No Annual Limit

Please also refer to ***EXCLUSION AND GENERAL LIMITATIONS*** beginning on page 37 and Plan rules on ***SUBROGATION (third party recovery)*** and ***COORDINATION OF BENEFITS*** on pages 62-63 and 70-74.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
(1) Annual Deductible (Applies to all expenses unless noted. You must pay all the costs up to the deductible amount before the Plan begins to pay.) **Note: Does not include coinsurance**	**MEDICAL DEDUCTIBLE AMOUNT** **Per Person: You pay $270 per person per calendar year.** **Family: You pay $750.00. Three family members must meet the $270.**	
(2) Other Deductibles	**$100 per person/$300 family for Dental Expenses**	
(3) Out-of-Pocket Maximum (Is the most you could pay in a year for covered services.)	**Per Person $2,000**	**Per Person: No Limit**
(4) Major Medical Benefits	**There are no annual or lifetime dollar maximums on Essential Health Benefits under the Plan pursuant to the Affordable Care Act.**	
(5) Percentage Payable **Coinsurance Limit** **Hospital Services** **Inpatient Hospital Expenses**	For Covered Expenses, the percentage payable will vary between 50% and 100%, depending on the particular Preferred Provider or Non-Preferred Provider that is utilized. ***The use of Preferred Providers will reduce your out-of-pocket expense.*** The Non-Preferred provider rate in the Reno or outside Reno/Sparks area is 70% of the Scheduled Allowance. After the deductible is met, once a Participant has incurred $10,000 of Covered Expenses in a calendar year, the Plan will pay 100% of Covered Expenses for the remainder of that calendar year. Charges which have been reduced under the Plan due to out-of-pocket amounts in excess of Covered Expenses are not applied toward either the $10,000 Coinsurance Limit or the calendar year deductible. ***Non-Preferred Provider Outside Reno/Sparks Area*** — Percentage of Scheduled Allowance — 70% ***Preferred Provider*** — Percentage of discounted fees — 80% ***Non-Preferred Provider within Reno/Starks Area*** — Percentage of Scheduled Allowance — 70% 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 Trust Fund.	
BENEFIT	**NETWORK PROVIDERS THE PLAN PAYS**	**NON-NETWORK PROVIDERS THE PLAN PAYS**
(6) Hospital Benefits	**(Calendar Year Deductible Applies)**	
• **Inpatient Services** (facility fee, physician/surgeon fees) (Pre Auth. Required).	* 80%	70% of Schedule Allowance, patient pays the excess.
• **Extras**	* 80% of Schedule Allowance, except payment not to exceed $50 for physiotherapy in a convalescent hospital during a continuous period of disability.	70% of Schedule Allowance, patient pays the excess.
• **Emergency Room** (Limited to 6 visits per year).	80% plus $25 copay charge per emergency room	70% of Schedule Allowance plus $25 copay charge per emergency room
• **Urgent care**	*80% of Schedule Allowance	70% of Schedule Allowance, patient pays the excess.
• **Outpatient Services** (Facility fee, physician/surgeon fees) (Pre Auth. Required).	* 80% of Schedule Allowance.	70% of Schedule Allowance, patient pays the excess.

(7) Ambulance		**(Calendar Year Deductible Applies)**
• **Maximum**	70% for a surface ambulance. Air ambulance subject to medical review.	70% of Schedule Allowance, patient pays the excess.
(8) Physician Services		**(Calendar Year Deductible Applies)**
• **Office Visits**	80% of Discounted fees	70% of Schedule Allowance, patient pays excess
• **Specialist Visits** (Chiropractic care 25 visits/year) (Acupuncture 15 visits/year)	80% - 100% of Discounted fees	70% of Schedule Allowance, patient pays excess
• **Anesthesia**	80% of Discounted fees	70% of Schedule Allowance, patient pays excess
• **Hospital Visits**	80% of Discounted fees	70% of Schedule Allowance, patient pays excess + co-pay.
• **Surgical Care**	80%	70% of Schedule Allowance, patient pays excess
• **Musculoskeletal Manipulation** (Limited to 25 visits per calendar year)	80%	70% of Schedule Allowance
• **Diagnostic Laboratory**	80% - 100% (but No Charge if radiology and lab test for Annual Physical Exam).	70% of Schedule Allowance
• **Prosthetic Devices and Medical Equipment**	80% - 100% (requires doctor's order)	70% of Schedule Allowance
• **Physical Therapy:** (30 visits per calendar year)	80% of Schedule Allowance	70% of Schedule Allowance
• **Skilled Nursing** (Maximum 100 days)	50% of Schedule Allowance	50% of Schedule Allowance
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
BENEFIT	**THE PLAN PAYS**	**THE PLAN PAYS**
(9) Diagnostic Coverage (If you have a Test)		**(Calendar Year Deductible Applies except if performed in Lab Corp. or Quest Labs)**
• **X-ray Procedures**	80% of Schedule Allowance but No Charge if radiology for Annual Physical Exam.	70% - patient pays excess over Schedule Allowance (No Charge if radiology for Annual Physical Exam). (
• **Laboratory Procedures**	80% - 100% of Schedule Allowance but No Charge if lab test for Annual Physical Exam. (No Deductible if received at LabCorp & Quest).	70% - patient pays excess over Schedule Allowance (No Charge if radiology for Annual Physical Exam). (No Deductible if received at LabCorp & Quest).
• **Imaging** (CT,PET scans, MRIs) (Pre Auth. Required by theTrust Fund)	80% of Schedule Allowance	70% - patient pays excess over Schedule Allowance
(10) Mental Health Care		**(Calendar Year Deductible Applies)**
• **Inpatient** (Pre Auth. Required by Trust Fund).	80% of Schedule Allowance. Same basis as benefit provided for any other illness.	70% - patient pays excess over Schedule Allowance.
• **Outpatient**	80% of Schedule Allowance	70% - patient pays excess over Schedule Allowance.
(11) Maternity Benefits		**(Calendar Year Deductible Applies)**
• **Coverage** (Office Visits,	Treatment of pregnancy shall be on the same basis as the treatment for any illness.	

Childbirth/Delivery professional Services/Facility Services) (For employee or spouse only)	80% of Schedule Allowance 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.	70%- patient pays excess over Schedule Allowance
(12) Substance Abuse Benefit		**(Calendar Year Deductible Applies)**
• **Coverage**	*Inpatient -80% of network allowance 70% Non-Network Provider (Pre-Authorization Required by Trust Fund office). *Outpatient -80% of network allowance 70% Non-Network Providers *Detox while inpatient -80% of network allowance 70% Non-Network	
(13) Home Health Care Benefit		**(Calendar Year Deductible Applies)**
• **Coverage**	80%, maximum visits 100 per calendar year. Maximum benefit per visit is $35, nutritional counseling maximum benefit is $50 per calendar year.	70% - patient pays excess over Schedule Allowance. Maximum visits 100 per calendar year.
(14) Hospice Care Benefit		**(Calendar Year Deductible Applies)**
• **Coverage**	80% of Schedule of Allowance	70% - patient pays excess over Schedule Allowance.
(15) Additional Accident Benefit	(Calendar Year Deductible **DOES NOT** Apply)	
• **Coverage**	100% up to $300.00 for additional accidental benefit for charges incurred within 90 days of accident.	70% - patient pays excess over Schedule Allowance.
(16) Adult Preventive Care/Screening/Immunization	(Calendar Year Deductible **DOES NOT** Apply for Employee & Spouse only).	
• **Coverage** (Limited to one exam per year for employee & Spouse only)	80% of Schedule Allowance but No Charge for Annual Physical Exam. Up to $33 per year for Flu Shots per participant/Dependent. Up to $224.00 per year for pneumococcal shots and up to $172.00 per year for shingles.	70% - patient pays excess over Schedule Allowance but 100% for Annual Physical Exam.
(17) Well Child Care (Preventive Care) Benefit		**(Calendar Year Deductible Applies)**
• **Coverage** (includes routine diagnostic testing or routine childhood vaccinations up to age 19 in accordance with Recommendations for Preventive Pediatric Health Care by American Academy of Pediatrics) **1. The charge of an acute care hospital for routine nursery care furnished to a newborn well baby while the mother is an inpatient.** **2. The charge of a physician for the initial pediatric examination of a**	80% of Schedule Allowance. 80% of Schedule Allowance.	70% - patient pays excess over Schedule Allowance. 70% - patient pays excess over Schedule Allowance.

newborn performed before the child is released from nursery care. **3. The charges of a physician for no more than 15 outpatient visits through the age of 2 years.**	80% of Schedule Allowance.	70% - patient pays excess over Schedule Allowance.
(18) Well Adult Care Benefit	(Calendar Year Deductible **DOES NOT** Apply)	
• **Coverage** (Physical Examination only to member and spouse) **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. **2. <u>Adults</u>** PSA blood test and digital rectal examination, as recommended by a physician. **3. Coronary Calcium Scoring CT scan**	100% of Schedule Allowance (Annual Physical) 1 per calendar year including labs & x-rays (Annual mammograms & Papsmear 80% of Schedule Allowance. Subject to Deductible) (Annual PSA and digital rectal exam 80% of Schedule Allowance. Subject to Deductible) 100% of Schedule Allowance	1 per calendar year including labs & x-rays 100% - patient pays excess over Schedule Allowance (Annual Physical) (Annual mammograms & Papsmear 70% of Schedule Allowance. Subject to Deductible) (Annual PSA and digital rectal exam 70% of Schedule Allowance. Subject to Deductible) 70% - patient pays excess over Schedule Allowance.
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
BENEFIT	**THE PLAN PAYS**	**THE PLAN PAYS**
(19) Dental & Orthodontic Care Benefit	(Dental deductible **DOES NOT** Apply for Routine check-up) **(Separate Dental Deductible Applies but no Deductible for Orthodontic Benefit. $100.00 Individual Deductible & $300.00 Family Deductible for Basic & Major Services Only).**	
•Dental Children's Coverage (No Annual maximum if under age 19 but $2,500 Annual limit if over age 19 through age 25). **•Dental Adult Coverage** (Annual Limit of $2,500) **•Orthodontic Adult Coverage** (Lifetime Limit $1,500) (Banding Fee Limit $500.00) **•Orthodontic Child Coverage** (Lifetime Limit $2,500) (Banding Fee Limit $500.00)	95% of Schedule Allowance 95% of Schedule Allowance 80% of Schedule Allowance 80% of Schedule Allowance	95% of dental non-PPO fee schedule 95% of dental non-PPO fee schedule 80% of dental non-PPO fee schedule 80% of Schedule Allowance
(20) Vision Care Benefit	(Calendar Year Deductible **DOES NOT** Apply)	
• **Coverage (Adult & Children)**	*No Deductible *Paid at 80% of billed charges *Contacts OR Frames – Every 12 months *Lenses & Exam – Every 12 months 2 Prescription Safety Glasses/Year	*No Deductible *Paid at 80% of billed charges *Contacts OR Frames – Every 12 months *Lenses & Exam – Every 12 months 2 Prescription Safety Glasses/Year
(21) Prescription Drugs (through OPTUM RX)	**(Separate Prescription Drug Deductible Applies.)** (Up to 34 day	

	supply retail; up to 90 day supply for maintenance drugs, equal $30 copay for mail)	
• **Generic Drugs** • **Preferred Brand Drugs** • **Non-Preferred Brand Drugs** • **Specialty Drugs** (Pre Auth. Required).	$10 copay (retail & mail order) $10 copay (retail & mail order) $10 copay (retail & mail order) $5 copay (retail & mail order)	Not Covered (mail); After $10 copay plus non-covered charge (retail). Not Covered (mail); After $10 copay plus non-covered charge (retail). Not Covered (mail); After $10 copay plus non-covered charge (retail). Not Covered
	***Pay 100% of discounted amount and send in for reimbursement.**	

****IMPORTANT****

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

III. DEATH BENEFITS

A. DEATH BENEFITS

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

Category	Death Benefit
Active Employees under age 65	$3,000
Spouse	$1,000
Dependent Child Up to Age 26 years	$1,000

B. BENEFICIARY

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

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

1. To your surviving spouse (gets everything);
2. If you have no surviving spouse, in equal shares to your natural or legally adopted children;
3. If you have no surviving spouse and no surviving children, in equal shares to your parents (or surviving parent gets everything);
4. If you have no surviving spouse, no surviving children and no surviving parents, in equal shares to your siblings (or surviving sibling gets everything); and
5. If you have no surviving spouse, no surviving children, no surviving parents and no surviving siblings, benefits would be paid to your estate.

C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Plan provides death benefits and accidental death and dismemberment benefits for Employees and Retirees and Dependents through The Union Labor Life Insurance Company.

To file a claim for death benefits or Accidental Death or Dismemberment Insurance, call the Trust Fund Office at (775) 826-7200.

An additional benefit will be paid for any of the following losses occurring on or off the job through purely accidental means, if the loss occurs while the insurance was in force, within 365 days after the injury, and due to an injury independent of all other causes.

For Participants under age 65, the full amount of the Accidental Death and Dismemberment benefit, which is $3,000, will be paid for the loss of:

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

One-half of the amount of your Accidental Death and Dismemberment benefit or $1,500 will be paid for the loss of one hand, one foot or the sight of one eye.

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

D. EXCLUSIONS – DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Payment for all losses due to any one accident may not exceed the full amount of your benefit. However, the benefits paid for one loss will not prevent further payment for losses resulting from subsequent accidents.

The Plan provides that no benefits are payable for any loss resulting from:

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

IV. IMPORTANT INFORMATION REGARDING YOUR PLAN BENEFITS

A. ENROLLMENT PROCEDURE

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

350Plumbers.com to obtain an Enrollment Form.

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

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

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

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

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

B. HOW TO FILE YOUR CLAIMS

1. Obtain a Claim Form. Obtain a claim form from the Trust Fund 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. You can obtain a Claim form by contacting the Trust Fund Office or visiting the website at **350Plumbers.com**.

ALERT—ONE YEAR TO FILE CLAIMS

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

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 Trust Fund Office. You do not need a new Claim Form as long as these itemized bills are for your existing claim.

3. Be sure your bills are itemized. The following information must be indicated on the bills

or Claim Form submitted:

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

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

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

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

Benefits are payable according to the discounted fees and 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.

D. DISCLOSURE STATEMENT-GRANDFATHERED PLAN

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

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

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

PLAN DOCUMENT

U.A. LOCAL 350 HEALTH, WELFARE & VACATION PLAN

ARTICLE I: ESTABLISHMENT AND OPERATION OF THE PLAN

SECTION 1.01 ESTABLISHMENT OF PLAN

1. **Restatement of Plan**. The Board of Trustees of the U.A. Local 350 Health and Welfare Trust restates the U.A. Local 350 Health, Welfare, and Vacation Plan ("Plan") by this Plan Document effective as of October 1, 2021.

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

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

SECTION 1.02 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 or Trust Fund Office employee is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

SECTION 1.03 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 or Trust Fund Office and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Trustees. Plan definitions are in Article V beginning on page 40.

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

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

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

4. **Employer Contributions**: Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with U.A. Local 350. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. The Employer's hourly contribution rate is subject to change at any time if agreed to by the bargaining parties. The bargaining parties also may allocate additional or different contribution amounts to help fund the Plan.

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

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

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

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

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

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

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

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

If an Employee or an eligible dependent of the Employee has any outstanding liability for fraudulently paid claims, neither the Employee nor the Employee's eligible dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by an Employee or eligible dependent may be disregarded by the Plan, and payments of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulent claims have

not been repaid when an Employee or eligible dependent incurs covered charges, the Employee or eligible dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited.

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

SECTION 1.04 YOUR RESPONSIBILITIES

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

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

WARNING – FRAUD AGAINST PLAN

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

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

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

ARTICLE II: ELIGIBILITY RULES FOR ACTIVE EMPLOYEES

SECTION 2.01 - ELIGIBILITY (Active Employees)

An Employee is eligible to participate in this Plan if he/she is an Employee of a Contributing Employer and works under a Collective Bargaining Agreement with U.A. Local 350.

A Participant may enroll in this Plan both as an Employee and as a Dependent. Benefits will be provided to the Participant as an Employee and as a Dependent consecutively, up to maximum amounts provided by the Plan, but in no event in excess of the actual Covered Expenses incurred.

1. Initial Eligibility Provisions for Collectively Bargained Employees

An hourly rate collectively bargained Employee is initially eligible for Benefits on the first day of the month following a period of not more than six consecutive calendar months during which he worked at least 480 hours in Covered Employment for one or more Contributing Employers. (Covered Employment is work under a collective bargaining agreement with U.A. Local 350.). You will then be covered on the first day of the month following the month in which you have accumulated a reserve equal to the required months of coverage.

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

2. Continuation of Eligibility for Collectively Bargained Employees – Hours/Hour Bank

After the Participant has satisfied the initial eligibility rules above, his hours in excess of 120 in a month will be credited to his hour bank. 120 hours are deducted from the Active Employee's Hour Bank Account for each month of eligibility. The maximum hours in an Hour Bank Account may not exceed 960 hours (8 months) after the deduction of 120 hours for the current month's eligibility. The purpose of the Hour Bank Account is to provide continued coverage for Participants who, due to circumstances beyond their control, would not otherwise be able to maintain such coverage through hours currently reported to the Plan by Contributing Employers. If you fail to have 120 credited hours in an eligibility month, the number of credited hours necessary to make up the difference will be deducted from your hour bank. **Your hour bank is not a vested benefit. The hours in your hour bank may, at any time, be limited, changed or extinguished through Trustee action. Your hour bank also has no monetary value**.

Example: ***You work 120 hours in March. Your hours for March provides coverage for the corresponding month of April***

3. Eligibility Provisions for Non-Collectively Bargained Employees

A person who is a non-collectively bargained monthly Employee, such as an employee of U.A. Local 350, is eligible for Benefits on the first day of the month following the month in which the Contributing Employer's written election to enroll non-collectively bargained Employees is received by the Trust Fund Office, subject to the following:

a. An individual Employer is required to execute a Subscription Agreement with the Plan in the manner and on a form approved by the Board of Trustees. Monthly contributions are an amount determined by the Board of Trustees as changed periodically.

b. New non-collectively bargained Employees of a Contributing Employer who have elected to enroll such Employees in the Plan will be eligible for coverage on the first day of the second calendar month following employment but no later than 90 days of his/her date of hire and assuming the required contributions have been made; and

c. Monthly Contributions from non-collectively bargained monthly Employees do not provide an Hour Bank Reserve Account accumulation. Non-Collectively bargained employees are not entitled to an Hour Bank Reserve Account.

4. Freeze of Balance in Hour Bank Account

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

5. Cancellation of Hour Bank Account

An hourly rate Collectively Bargained Employee will have his Hour Bank **immediately reduced to zero** when either of the following circumstances occurs:

a. The Active Employee permits a Contributing Employer to contribute to the Fund on the basis of fewer hours than he actually worked for the Contributing Employer.

b. The Active Employee performs work of the type covered by the Collective Bargaining Agreement for an employer who is not a Contributing Employer.

6. Termination of Active Employee Eligibility

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

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

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

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

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

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

f. The date the Plan terminates.

7. Reinstatement of Active Employee Eligibility

If an Active Employee's eligibility terminates:

a. An hourly rate Employee will have eligibility reinstated on the first day of the calendar month next following the date the number of hours in his Reserve Account reaches a total of at least 120, provided the 120 hours were accumulated within 6 months immediately following the date his

eligibility terminated. If eligibility is not reinstated within the 6-month period, any reserve hours in the Reserve Account will be forfeited and the Employee must reestablish initial eligibility.

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

8. Self-Pay Provisions for Active Employees

a. Continued Coverage while in Uniformed Service of the United States.

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

If an Active Employee (and his eligible Dependents) was eligible for Benefits as of the date of entry into service in the Uniformed Services of the United States, and the Active Employee's absence was due to a uniformed services leave, an Active Employee or eligible Dependent may elect to continue coverage under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A premium for continuation coverage under USERRA will be in an amount established by the Plan. Such premium shall be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

- 18 months beginning on the day that the uniformed service leave commences; or
- a period ending on the day after the Employee fails to return to employment within the time allowed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

b. Continued Coverage as the Right of a Labor Dispute

If coverage terminates because an Active Employee ceases active work as the result of a labor dispute, coverage may be continued up to a maximum of six months after an Active Employee's Hour Bank Account is exhausted, subject to the following conditions:

- Monthly self-payments, in an amount determined by the Trustees and as amended from time to time, must be received by the Fund Office by the first day of the month for which coverage is desired.
- Self-payments must be continuous.

SECTION 2.02- CONTINUATION OF COVERAGE - COBRA COVERAGE

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires group health plans offer covered Employees and their Dependents the opportunity to elect to pay for a temporary extension of health coverage (called "COBRA

Continuation Coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage, the Employee, spouse and/or Dependent(s) must make timely monthly payments directly to the Plan.

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

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

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

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:

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

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

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

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

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

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

Within 45 days after the Covered Person notifies the Trust Fund Office of a qualifying event, the Trust Fund Office shall notify a Covered Person who is eligible for continued coverage of the following:

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.

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

Qualifying Event Notice Special Extension Rules- Temporary.
Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, the temporary extended relief for you or your Dependents to give the Trust Fund Office Notice of a Qualifying Event or receipts of the notice of COBRA continuation coverage, for **Qualifying Events occurring on or after March 1, 2020**, is temporarily extended but will terminate the earlier of: (1) one year from the date you (or your Dependents) were first eligible for an extended deadline or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

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

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.

COBRA Election Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, you or your Dependent's 60 day period right to elect COBRA, for **Qualifying Events occurring on or after March 1, 2020**, is temporarily extended and will terminate the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from the later of the date you are furnished the election notice or the date you lose coverage) or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

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 Trust Fund Office, or, if mailed, on the 45th day after the date the written request is postmarked.

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

COBRA Premium Payments Special Extension Rules- Temporary. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, for **Qualifying Events on or after March 1, 2020**, the initial COBRA payment and ongoing monthly premium payments have been temporarily extended. This means if COBRA coverage is first elected during the Outbreak Period, your initial COBRA payment is temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from 45 days from the date of your COBRA Election) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. For all ongoing monthly premium payments for which coverage is elected, coming due during the Outbreak Period are also temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (plus 30 days because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 days of the due date) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

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

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

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

2. **FAILURE TO TIMELY PAY COBRA PREMIUM**. The end of themonth for which a Covered Person has made the required payment for continued coverage; the date on which any payment for continued coverage is not made in a timely manner. A payment shall be considered received in a timely manner if it is received within 31 days after becoming due;

3. **COVERAGE UNDER ANOTHER PLAN**. The date a Covered Person becomes covered under another group health plan;

4. **ENTITLED TO MEDICARE**. After an election of COBRA coverage, the date a Covered Person becomes entitled to benefits under Medicare;

5. **NO ACTIVE PLAN COVERAGE**. The date on which the Plan ends coverage for the Covered Persons to which a person receiving continued coverage belonged to before his or her continued coverage began.

6. **EMPLOYER NO LONGER CONTRIBUTES**. The date your employer, who contributed on

your behalf, ceases to be a contributing Employer.

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

COBRA QUICK REFERENCE CHART

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

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

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

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

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

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

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

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

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

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

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

H. **RETIREE SPOUSE SELF-PAYMENT EXTENSION PROVISION** – If COBRA Continuation Coverage for the spouse of a Retired Employee terminates due to expiration of the maximum 36-month duration from the date of the Employee's Medicare entitlement, coverage may be continued under this self-payment provision for a maximum duration of thirty-six (36) months.

1. This self-payment extension provision is not applicable if COBRA Continuation Coverage terminated for failure to pay premiums on a timely basis.

2. Monthly self-payments, in an amount determined by the Board of Trustees and as amended from time to time, must be received by the Fund Office by the first day of the month for

which coverage is desired.

3. Monthly self-payments must be made continuously for coverage to remain in force.

SECTION 2.03 – ELIGIBILITY (Retired Employees Continued Coverage)

A. ***For Retired Collective Bargained Employee.*** To be eligible for continued coverage upon retirement under the Active Plan, a Retired Employee must:

1. Be 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 based on pension credit earned for work performed under a Collective Bargaining Agreement with U.A. Local 350;

2. Attained age 60;

3. Was eligible for this Plan's Benefits for at least 24 months during the 60 months before the Employee turned age 60 or the date of retirement, if later;

4. Was eligible for benefits from this Plan for at least 120 months out of the last 180 months immediately prior to retirement;

5. Was working in covered employment (or was on the Out of Work List seeking Covered Employment) during the 3-month period before turning age 60. The retired Employee must not be on U. A. Local 350's Out of Work List at age 60 or thereafter;

6. Has maintained and continues to maintain current membership with U.A. Local 350 during the 60 months immediately prior to retirement and continues to pay U.A. Local 350 dues;

7. The retired employee is not working non-covered employment in the Plumbers and Pipefitters Industry; and

8. Timely pays any required monthly premium for such coverage if applicable.

IMPORTANT: If all these requirements are met, COBRA continuation coverage can be continued once the timely payment of the appropriate premium is made by the retired participant until the Retired Employee is eligible for Medicare. Once the Retiree is eligible for Medicare the coverage will terminate. Please refer to the separate U.A. Local 350 Retiree Health and Welfare Plan booklet available upon request by contacting the Trust Fund office for more information about the separate retiree health and welfare plan details.

B. For Retired non-Collectively Bargained Employee

1. The retired Employee has attained age 62; and

2. The retired Employee was eligible for this Plan's Benefits for at least 24 months during the five years before the Employee turned age 60 or the date of retirement.

IMPORTANT: If all these requirements are met, COBRA continuation coverage can be continued once the timely payment of the appropriate premium is made by the retired

participant until the Retired Employee is eligible for Medicare. Once the Retiree is eligible for Medicare the coverage will terminate. Please refer to the separate U.A. Local 350 Retiree Health and Welfare Plan booklet available upon request by contacting the Trust Fund office for more information about the separate retiree health and welfare plan details.

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 2.04 - COVERED DEPENDENTS

A Covered Dependent means a lawful spouse, child, or children through the end of the month in which the child attains age 26 regardless of whether the child is eligible for coverage through his/her own employment and/or through the dependent child's spouse's employment. If the Participant and spouse are legally separated or divorced, the spouse is no longer eligible for coverage.

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

NOTICE OF NEW DEPENDENT

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

a. Dependent Spouse

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

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

b. Dependent Children

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

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

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

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

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

Active Employees shall register their eligible Dependents upon forms provided by the Fund and shall furnish such other information regarding family status as the Trustees may require from time to time. Marriage certificates are required to provide coverage for a spouse under the Plan. Birth certificates are required to provide coverage for a Dependent child under the Plan. Copies of Social Security Number Cards for All Dependents are also required.

SECTION 2.05 – EXTENSION OF BENEFITS – SHORT TERM DISABILITY

If the Employee is Totally Disabled and under the care of a Physician at the time coverage ends due to loss of eligibility, Basic Medical benefits and Major Medical benefits shall be extended for Covered Expenses incurred by that Employee after the date of termination. Extended Basic Medical benefits and major Medical benefits are subject to the same terms that would have applied if Basic and Major Medical benefit had remained in force.

a. Extended Employee benefits are available only for Covered Expenses incurred:
   (1) for treatment of the specific Illness or Injury that caused the Employee's Total Disability;
   (2) while the Employee remains Totally Disabled;
   (3) for a period not to exceed twelve months of extended Major Medical benefits.

b. Employee extension of benefits is provided until the first of the following occurs:
   (1) the employee is no longer Totally Disabled; or
   (2) the date on which the Employee becomes covered under any plan providing benefit similar to the extended benefits of this Plan; or
   (3) upon completion of the maximum period of extension of benefits for Basic Medical benefits or Major Medical benefits.

c. Written certification must be submitted by a Physician that the Employee is Totally Disabled. The Fund must receive this certification within 31 days of termination. At least once every 60 days while benefits are extended, the Fund may request proof that the Employee continues to be Totally Disabled (and eliminate such coverage if proof is not timely provided).

SECTION 2.06 – EMPLOYEE AND/OR DEPENDENT/COST OF COVERAGE

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

SECTION 2.07 – TERMINATION OF DEPENDENT ELIGIBILITY

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

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

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

SECTION 2.08 – DEATH OF AN EMPLOYEE

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

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

SECTION 2.09 – SPECIAL ENROLLMENT RIGHTS

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

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

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

3. Special Enrollment Allowed Under The Children's Health Insurance Program Reauthorization

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

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

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

4. **Special Enrollment Extension Rules- Temporary Only During COVID-19 Public Health Emergency Period.** Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, if you had a birth, marriage or adoption **as of March 31, 2020**, your 30-day period right to special enroll an eligible dependent in the Plan upon birth, marriage, or adoption is temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your extended relief exceed One (1) year. If your dependent loss coverage under CHIPRA or Medicaid as of March 31, 2020, your 60-day period to special enroll an eligible dependent in the Plan upon a loss of CHIPRA or Medicaid coverage is also temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your Dependent's extended relief exceed One (1) year. **Please contact the Trust fund Office to determine your individualized situation.**

ARTICLE III: MEDICAL BENEFITS (Covered Expenses)

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

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 Plan 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 by the Plan. The amount of the deductible for each Participant is the first $270 of Covered Expense incurred in a calendar year will satisfy the family deductible maximum of $750 for that particular calendar year. Three $270 deductibles met in full by three Participants in the same family during a calendar year will satisfy the family deductible maximum of $750 for that particular calendar year.

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 80% percentage of the first $10,000 of Covered Expenses incurred by each Participant in a calendar year, and 100% thereafter for the remainder of that calendar year. (You pay$2,000 of the first $10,000 of Covered Expenses).

Percentages payable vary between 50% and 100%, depending 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.

Charges which have been reduced under the Plan due to out-of-pocket amounts in excess of Covered Expenses are not applied toward the coinsurance limit.

SECTION 3.02 – INPATIENT HOSPITAL SERVICES

HOSPITAL AND MEDICAL REVIEW PROGRAM
Provided by the Fund
For Employees and their Eligible Dependents

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

This means that you or your Physician need to notify the Trust Fund PRIOR TO the Hospital admission. The Trust Fund will determine whether or not the Hospital confinement is Medically Necessary, and if Medically Necessary, the number of precertified 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 Trust Fund 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 Trust Fund Office.***

Emergency confinements where prior approval from the Trust Fund 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 Trust Fund office as soon as possible after being admitted. The Trust Fund will conduct a **Continued Stay Review (Concurrent Review)** to determine Medical Necessity.

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).

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 you 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 Trust Fund Office may consult with your Physician to discuss the case further. If the Trust Fund Office 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**.

If a Participant is admitted to a Hospital that does not participate in a **Concurrent Review Program**, the confinement will be reviewed by the Trust Fund Office after the Participant leaves the Hospital. If the Trust Fund Office 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**.

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

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.

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 Trust Fund, 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.

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 Trust Fund Office or refer to the Preferred Provider Listing for information on the percentages payable and the names of the current Preferred Providers.

The Plan has expanded the following hospital services under **Renown Telehealth:**

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

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

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.

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:

- while the Participant is confined as an inpatient in a Hospital, and
- 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 OR REHABILITATION HOSPITAL

If a Participant is confined in a Hospital for at least three consecutive days and is then admitted to a Convalescent Hospital/Rehabilitation Hospital or Skilled Nursing Facility within seven days of Hospital discharge, the Plan will reimburse up to 50% of the discounted rate for a PPO Provider or 50% 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 authorized by the Trust Fund 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 hermodialysis, radiation therapy, and chemotherapy require prior authorization.

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:	80% of the negotiated rates
Non-Contract Provider:	70% 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 authorized by the Trust Fund 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% or 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. Routine well child care office visit, preventive immunizations, and related routine laboratory testing of a Dependent child's life up to age 19;

4. 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;

5. Diagnostic x-rays, radium or radioactive isotope therapy performed by a Physician or Radiologist, or diagnostic laboratory examinations performed by a Physician or pathologist;

6. 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.

7. Administration of oxygen, casts, splints, and surgical dressings.

8. Blood Transfusion, including blood processing and cost of un-replaced blood and blood products.

9. Radiation therapy and chemotherapy.

10. 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.

11. Two support hose stockings are covered per calendar year if medically necessary and supported by a doctor's orders.

12. Following cataract surgery, the first lense replacement is covered.

13. Wigs due to loss of hair after radiation therapy or chemotherapy up to $370 lifetime maximum.

14. 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.

15. Flu vaccinations up to $33.00 of the cost for each participant and dependent each calendar year. The amount covered by the Plan for a flu vaccination shall not be reduced by the Plan's deductible or coinsurance provisions.

16. Outpatient laboratory and other diagnostic testing that is required by law and order by a physician to determine the evidence-based diagnosis for the cause of pain, or for the determination of the presence or level of controlled substance in a patient is a covered benefit under the Plan.

17. Circumcision for males from birth to of age of 10 weeks, and if after 10 weeks needs to be determined to be medically necessary.

18. Pneumococcal vaccinations up to $224.00 for each participant and dependent each calendar year (not subject to deductible or coinsurance). Shingles vaccinations up to $172.00 for each participant and dependent each calendar year (not subject to deductible or coinsurance).

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, and
- usable only by the Patient, and
- of no further use when medical need ends, and
- not primarily for the comfort or hygiene of the Participant, and
- not for environmental control, and
- not for exercise, and
- manufactured specifically for medical use, and
- 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 negotiated Contract Rate or Schedule of Allowances (if applicable) purchase price for durable medical equipment are <u>not</u> Covered Expenses.

SECTION 3.9 – MENTAL HEALTH BENEFITS

There are no maximum number of days limit for hospitalization due to a medically necessary mental health disorder.

Outpatient psychotherapy and psychological testing is payable at 80% of discounted fees for Contract Providers and 70% of schedule allowance for Non-Contract Providers.

SECTION 3.10 – HOME HEALTH CARE BENEFIT

Home Health Care Services need to be reviewed by the Trust Fund 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 is services were performed in a Hospital or Convalescent Hospital.

Covered Expenses for care rendered by a *Preferred Provider* is reimbursed at 80% of discounted fees. Covered Expenses for care rendered by a *non-Preferred Provider* is reimbursed at 70% 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 Trust Fund before treatment starts in order to determine Medical Necessity. If precertification is not received, services rendered are subject to retrospective review by the Trust Fund.

- 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:	80% of the negotiated rates
Non-Contract Hospital outside Reno/Sparks	70% of the Scheduled Allowance

Treatment of Alcohol or Substance Abuse has the following cost-sharing and pre-certification requirements:

(1) Detox 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 80% of contract rate for PPO providers and 70% of Out of Network Fee Schedule for non-PPO provider. Pre-certification is required.

(2) Pre-certification is required for Alcohol and/or Substance Abuse Counseling/Treatment.

SECTION 3.12 – DIALYSIS.

Participants must apply for Medicare as a secondary payer within the first 90 days of being diagnosed with End Stage Renal Disease ("ESRD").

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. Effective August 1, 2021, the Plan also covers acupuncture for any mental health or substance abuse benefits, with no calendar limits for visits.

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 as medically necessary.

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 an Employee: when an Employee 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.

Covered Expenses (except bereavement counseling) of a *Preferred Provider* are reimbursed at 80% of discounted fees. Covered Expenses (except bereavement counseling) of a *non-Preferred Provider* are reimbursed at 70% 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 50% 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 at 100% for participation in a smoking cessation program, prescription drugs, or any over the counter treatments to stop smoking. Effective for claims incurred on or after February 1, 2020, office visits will also be covered at normal plan benefits.

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.

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 Trust Fund Office, the Plan will pay 100% of covered charges incurred in excess of a $10.00 co-payments for prescriptions (not injectables). 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.

SECTION 3.30 – COVERAGE OF PREVENTIVE CARE

(1) **Well Child Care Benefit Coverage.** Including routine diagnostic testing or routine childhood vaccinations up to age 19, in accordance with the Recommendations for Preventive Pediatric Health Care published by the American Academy of Pediatrics. Human Papillomavirus Virus (HPV) immunizations will be covered under the well child benefits. The Calendar Year Deductible applies. The Plan pays Network Providers 80% of the contract allowable rate. The Plan pays Non-Network Providers 70% of the Schedule of Allowances.

(2) **Member & Spouse Coverage.** Routine physical examination performed by a physician including expenses for radiology and laboratory testing (and coronary scoring scan) once per calendar year. Physical examinations are availably only for Active Participant and Dependent Spouse. The Calendar Year Deductible DOES NOT Apply. The Plan pays Network Providers 100% of contract allowable rate. The Plan pays 100% of Schedule of Allowance for Non-Network providers. If the Schedule of allowance is less than the Non-Network provider charges, you will owe the difference.

(3) **Papsmear.** The Plan covers papsmear once per calendar year. The Calendar Year Deductible applies. The Plan pays Network Providers 80% of the Schedule of Allowance. The Plan pays Non-Network Providers 70% of the Schedule of Allowance.

(4) **Mammogram.** The Plan covers mammograms once per calendar year for participants over age 35. The Calendar Year Deductible applies. The Plan pays Network Providers 80% of the Schedule of Allowance. The Plan pays Non-Network Providers 70% of the Schedule of Allowance.

(5) **Colonoscopy.** The Plan covers colonoscopy performed by a physician once per calendar year. Colonoscopies are available for Active Participant and Dependent Spouse ages 50 and older. The Calendar Year Deductible applies. The Plan pays Network Providers 80% of the Schedule of Allowance. The Plan pays Non-Network Providers 70% of the Schedule of Allowance.

(6) **Prostate Specific Antigen (PSA) and Digital Rectal Exam.** The Plan covers PSA and Digital rectal examinations once per calendar year. The Calendar Year Deductible applies. The Plan pays Network Providers 80% of the Schedule of Allowance. The Plan pays Non-Network Providers 70% of the Schedule of Allowance.

(7) **Vision Exam.** The Plan covers One (1) Annual routine vision examinations once every twelve months (year to date). The Calendar Year Deductible Does NOT apply. Vision examinations are available for Active Participant, Dependent Spouse and Dependent Children. The Plan pays Network Providers 80% of the Schedule of Allowance.

(8) **Dental Exam.** The Plan covers routine dental examinations twice per calendar year. The Calendar Year Deductible Does NOT apply. Routine dental examinations are available for Active Participant, Dependent Spouse and Dependent Children. The Plan pays Network Providers 95% of the Schedule of Allowance.

(9) **Shingles & Pneumococcal Vaccinations.** Effective August 1, 2021, the Plan covers and will reimburse pneumococcal vaccination up to $224.00 (not subject to deductible or

coinsurance) and shingles vaccination up to $172.00 (not subject to deductible or coinsurance).

SECTION 3.31 – HEARING AID BENEFIT

Medically necessary hearing aid benefits is a covered benefit under the Plan for all eligible Participants and Dependents. The Plan provides coverage at 90% of covered charges both in-network and out-of-network for medically necessary hearing aids, up to a maximum of $1,000 per hearing device, one device per ear in a four-year period. No payment will be made under this benefit for any other hearing related services such as hearing exams. No Deductible is applicable to this benefit.

SECTION 3.32 – LASIK/LASEK/PRK SURGERY

Medically necessary Lasik surgery is a covered benefit and is limited to $1,500 per eye not subject to the deductible or co-insurance. Lasik/Lasek/PRK surgery is allowed once in a lifetime.

SECTION 3.33- EATING DISORDERS.

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

SECTION 3.34 – AUTISM & BEHAVIORAL PROBLEMS/DEVELOPMENTAL DELAY.

Effective February 1, 2020, a diagnosis of autism is considered a mental health diagnosis and available benefits may include but are not limited to outpatient services such as psychotherapy, physical therapy, developmental delay, behavioral problems, learning disabilities, expenses in connection with hyperkinetic syndrome, Applied Behavioral Analysis (ABA therapy) as well as inpatient treatment if medically necessary. Benefits for autism are payable the same as any other covered illness.

SECTION 3.35 - COVID-19 Coverage During Public Health Emergency Period.

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

(d) other tests that the Secretary of Health and Human Services determines appropriate in guidance developed during the COVID-19 public health emergency period.

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

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

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

2. **Telehealth and Telemedicine Coverage.** Effective March 6, 2020 and during the period of the COVD-19 public health emergency, the Plan will cover, subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, the following virtual services provided by a medical practitioner: (a) telehealth/telemedicine visits (a visit between a medical practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5-10 minute check-in with a medical practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and medical practitioner through an online patient portal). The three (3) foregoing services must be performed consistent with guidelines published by the Centers for Medicare & Medicaid Services ("CMS") in order to be covered (FACT SHEET March 17, 2020). To clarify, medical practitioner is considered an Allied Health Practitioner for purposes of this amendment and the temporary amendment for telehealth/telemedicine coverage does include mental health/substance abuse disorder coverage.
3. **COVID-19 Vaccination & Immunization Coverage.** Effective the earlier of January 1, 2021 or 15 business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations the Plan, through its medical providers and pharmacy benefit manager, throughout the duration of the COVID-19 public health emergency, will cover approved COVID-19 vaccinations and immunizations, including the additional dose of booster shots. Subject to future government guidance, COVID-19 vaccinations will be available to all eligible participants and dependents at **no cost whether received in-network and out-of-network** and **without prior authorization** at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies through the Optum RX pharmacy benefit manager.

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

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

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

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

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

SECTION 3.36- Glucose Monitoring. Effective May 1, 2021, the Plan covers continuous glucose monitoring systems for diabetes management.

SECTION 3.37 – Speech Therapy. Effective June 1, 2021, the Plan covers speech therapy if deemed medically necessary as prescribed by a licensed physician.

SECTION 3.38 – Family Counseling Services. Effective August 1, 2021, the Plan covers Family counseling services.

SECTION 3.39 – Occupational Therapy. Effective August 1, 2021, the Plan covers Occupational Therapy if deemed medically necessary as prescribed by a licensed physician. Occupational Therapy is defined a medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

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.

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. Section 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). In addition, the Plan will not require history of a physical or mental health condition in its record before approving a claim for payment of medically necessary treatment for injuries incurred during an attempted suicide.

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

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

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

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

10. Services by a Non-Physician or a Relative or Member of Household. Services furnished

by (i) a Naturopath or any other provider not meeting the definition of Physician or Allied Health Professional, or (ii) charges made by a Relative of the Participant or a member of the Participant's household.

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

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

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

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

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

16. 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.

17. 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.

18. Physical Exams. Expenses for any examinations required for obtaining or maintaining employment, insurance or governmental licensing, school or sporting activities.

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

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

21. Excess of Annual Maximums For Non-Essential Health Benefits. Amounts in excess of any permitted limits placed on non-Essential Health Benefits.

22. 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.

23. 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.

24. Pregnancy of a Dependent Child. Expenses in connection with the routine normal pregnancy of a Dependent daughter or other non-spousal dependent. However, expenses in connection with treatment of Complications of Pregnancy for a Dependent daughter including emergency services related to pregnancy will be covered and considered as any other Illness.

25. 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.

26. Myofunctional Therapy. Myofunctional therapy.

27. 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.

28. Temporomandibular Joint Dysfunction (TMJ). Procedures and services for the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMJ) or disturbances of the temporomandibular joint.

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

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

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

ARTICLE V: DEFINITIONS

SECTION 5.01 – ACTIVE EMPLOYEE – Means each person who meets the eligibility rules of the Plan.

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 a practitioner of the healing arts (behavioral health practitioner, chiropractor, nurse practitioner, physician assistance, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist) who renders care or treatment within the limits set forth in the license issued to him/her by the applicable agency of the state in which he/she renders such care or treatment. The Allied Health Practitioner shall be reimbursed only for services covered by the Plan that would otherwise be covered if provided by a Physician.

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 Trust Fund 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 - COVERED EMPLOYEE – Shall mean the contributions specified by the Collective Bargaining Agreements to be made by the Employers to the U.A. Local 350 Health, Wealth and Vacation Trust Fund.

SECTION 5.09 – 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 5.10 – 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 5.11 – "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. The Plan has a contract with Optum Rx as its Pharmacy Benefit Manager.

SECTION 5.12 - 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 5.13 – "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 5.14 – "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 5.15 - FUND – Means the U.A. Local 350 Health, Welfare and Vacation Trust Fund.

SECTION 5.16 – 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 5.17 – 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 5.18 – "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 5.19 - 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 case 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 5.20 – "HOSPITAL PRECERTIFICATION" or "HOSPITAL STAY REVIEW" Shall mean the process whereby the Trust Fund Office 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 5.21 – 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 5.22 - ILLNESS – Means a non-occupational bodily disorder, infection, or disease and

all related symptoms and recurrent conditions resulting from the same cause.

SECTION 5.23 - 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 5.24 – 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 5.25 – "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 5.26- PARTICIPANT – Shall mean any person eligible for Benefits under the Plan, whether as an Eligible Employee or Eligible Dependent.

SECTION 5.27 – "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 5.28 - 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 5.29 - PLAN – Shall mean this document titled the U.A. Local 350 Health, Welfare, and Vacation Trust Fund Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

SECTION 5.30 – PLAN YEAR – Means September 1 of any year to August 31 of the succeeding year.

SECTION 5.31 – 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 5.32 – PREGNANCY – Means all pregnancies, childbirth, and voluntary termination of pregnancy for an Employee or Dependent Spouse only. Complications of Pregnancy will be considered as any other Illness.

SECTION 5.33 – 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 5.34 – 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 – SCHEDULE OF 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 **"SurgeryCenter"** 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 anesthetists 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 say 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.

SECTION 5.39 – ESSENTIAL HEALTH BENEFITS

Means benefits that fall within the categories below as determined by the Plan and Claims Administrator in their sole discretion and subject to the requirements of the Affordable Care Act:

(i) Ambulatory patient services
(ii) Emergency services
(iii) Hospitalization
(iv) Maternity and newborn care
(v) Mental health and substance use disorder services, including behavioral health treatment
(vi) Prescription drugs
(vii) Rehabilitative and habilitative services and devices
(viii) Laboratory services
(ix) Preventive and wellness services and chronic disease management
(x) Pediatric services, including oral and vision care

SECTION 5.40 – SCHEDULE OF ALLOWANCES

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

ARTICLE VI: PRESCRIPTION DRUG BENEFITS

Prescription Drug benefits described in this Article are available to eligible Active Employees and their eligible Dependents. Prescription Drug benefits are currently provided in contract with Optum Rx (the Plan's Pharmacy Benefit Manager). Information concerning prescription drug benefits, including a list of the pharmacies in the Optum RX retail pharmacy network can be obtained by calling Optum Rx toll- free at 1-800-797-9791. Additional information concerning prescription drug benefits can be obtained at the Optum Rx website at www.optumrx.com.

No benefit is available for prescription drugs obtained via mail order outside of the Optum Rx

network of participating pharmacies. If you use a non-participating pharmacy for mail order drugs you will be responsible for 100% of the cost of the prescription.

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, couth 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 (3 months) of purchase.

c. "Pharmacy Plan Manager (PBM) means a company or entity that has a contract with the Plan to administer, handle, manage, consult, and/or pay on behalf of the Plan prescription drug benefits.

d. "Specialty Drugs" means high-cost oral, inhalable, or injectable medications used to treat a person with complex or chronic medical conditions (physical, behavioral or developmental condition that may have no known cure, is progressive and/or is debilitating or fatal if left untreated or under-treated).

SECTION 6.02 – LIMITATIONS ON SUPPLY & COPAYMENT

The maximum **retail** 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. **Prescription mail order coverage will cover up to a 90-day supply.** A $10.00 co-pay will be applied for each. No co-pay applies if purchase at network provider pharmacy. Retail remains at a maximum benefit of 34 days with $10.00 co-pay.

	Network Provider	**Non-Network Provider**
Generic Drugs	*$10 copay (mail & retail)*	*Not covered (mail)* *After $10 copay plus non-*

		covered charge (retail).
Preferred Brand Drugs	*$10 copay (mail & retail)*	*Not covered (mail)* *After $10 copay plus non-covered charge (retail).*
Non-Preferred Brand Drugs	*$10 copay (mail & retail)*	*Not covered (mail)* *After $10 copay plus non-covered charge (retail).*
Specialty Drugs	*$5 copay (mail & retail)* Preauthorization required.	Not Covered

Savings Programs Through OPTUM RX.

Optum Enhanced Savings Program. This discount program may be available to you at no charge and could help you potentially save on medications and diabetic supplies not covered under the Plan. If you are already enrolled present your ID card and a prescription form from your doctor to any network pharmacy. If the Plan does not cover a medication, you can either receive it at a discounted cost through the Optum Savings Program or you can ask your doctor if a covered medication is right for you. To receive a discount on over-the-counter and other medications not covered by the Plan, a written prescription is still required. Please contact your doctor for this prescription.

For more information and to find a pharmacy near you, please visit optumrx.com or call Optum Rx customer service help desk at 1-800-356-3477.

Please note: Prescriptions filled using the Optum Enhanced Savings Program discount will not apply to your Annual out-of-pocket maximum or deduticble.

Optum Perks Prescription Relief Program. For those who recently had a change in health or prescription benefits plan, and no longer have health coverage, you can potentially still receive discounts on your prescriptions through the Optum Perks Prescription Relief Program. This program is a free pharmacy discount program giving certain individuals access to ongoing savings on prescriptions and continued access to mail order if your health coverage has ended. **For more information please contact Optum Rx customer service help desk at 1-800-356-3477 as this program is separately and independently administered through Optum (not through the Plan).**

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. The amount of the deductible is $10.00 per prescription after sending in prescription receipt for reimbursement.

SECTION 6.04 – COINSURANCE PAYABLE

After the deductible has been satisfied, the fund shall pay the following percentage of Covered Expenses:

Contract Provider: ***100% of the negotiated ratesafter $10 co-pay for retail and mail order. 100% of the discounted rate if at the pharmacy ($10 co-pay does not apply) IMPORTANT: Need to send in the prescription receipt for reimbursement within 3-months of purchase date.***

Non-Contract Provider: ***100% of the Scheduled Allowance shown in Appendix A after $10 co-pay for retail prescription drugs only. You are responsible for non-covered retail charges. There is no coverage for mail order drugs through non-contract provider.***

Participants can use an independent Discount card or a Pharmacy Discount without a reduction in Plan reimbursement in the following circumstances:

(1) If a participant is picking up a Generic Drug and the price using a Discount card or Pharmacy discount is less than the price charged by the Plan's Pharmacy Benefit Manager,
(2) If a participant is picking up a Brand Drug and the price using a Discount card or Pharmacy discount is $65.00 less than the price charged by the Plan's Pharmacy Benefit Manager, and
(3) If a participant is picking up a Specialty Drug and the price using a Discount Card or Pharmacy Discount is $150.00 less than the price charged by the Plan's Pharamacy Benefit Manager.

SECTION 6.05 – USE OF BRAND NAME DRUG WHEN GENERIC EQUIVALENT IS AVAILABLE.

Many prescription drugs are available as a trademark or "brand" name drug and a chemical or "generic" name drug. By law, brand and generic drugs must meet the same standards for safety and effectiveness. Obtaining generic drugs, whenever possible, can provide You with savings directly (by paying a lower copayment) and indirectly (because the Plan saves money – which ultimately benefits You).

If you take one of the brand name prescription drugs when a generic drug is available and medically appropriate, there are no benefits available for the brand name drug. Please contact the Trust Fund office for a copy of the brand name prescription drugs list.

SECTION 6.06 – PREFERRED ALTERNATIVE DRUGS.

Within each drug category, there are many therapeutic alternative drugs available. If you are taking a prescription drug for one of the therapeutic categories, the Plan will only provide coverage for the Preferred Alternative. If you attempt to fill a prescription for one of the "Excluded Medications" there will be no payment by the Plan. That does not mean you should stop taking your medication. However, you should talk to your doctor about possible alternative medication options. Please contact the Trust Fund office for a copy of the listed therapeutic categories.

SECTION 6.07 – STEP THERAPY AND PRIOR AUTHORIZATION REQUIRED FOR CERTAIN PRESCRIPTION DRUGS

OptumRx requires prior authorization for certain prescriptions before they are covered in order to promote safe and effective medication use in addition to helping keep Plan costs in check. Frequently, the newest drug being marketed is also the most expensive option, but is not necessarily the most effective. A less costly drug can provide the same medical results. Your doctor should go to Optum Rx's website to download a prior authorization request form at the following address: www.optumrx.com. The prior authorization forms can be found in the provider section under "Physician Community."

Step therapy program requires you to use a category prescription drug before being authorized to use a more expensive version of the same drug in other categories below the first category. With the step therapy program you may be asked to use a more cost effective drug before the Plan will pay for a higher priced drug. If you or your doctor have questions regarding the step therapy process, please contact Optum Rx at 1-855-672-3644 for preauthorization or with any questions regarding the Step Therapy program.

SECTION 6.08 – 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 ore 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;

m. Mail order prescriptions obtained outside of the participating network of pharmacies;

n. Specialty drugs obtained without prior authorization and specialty drugs obtained outside of the participating network of pharmacies.

ARTICLE VII: VISION CARE BENEFITS

Vision Care benefits described in this Article are available to eligible Active Employees and their eligible Dependents.

SECTION 7.01 – BENEFITS

If an examination or glasses/contact lenses are obtained, the Fund will pay benefits to the Participant, subject to the terms and conditions below, for:

a. Eye Examination: Eye examination by an ophthalmologist (M.D.) or optometrist (O.D.) once every twelve months (year to date) paid at 80-% at PPO provider;

b. Eyeglass Lenses: Eyeglass lenses including single, bifocal, trifocal or lenticular lenses once every twelve (12) months, if an examination indicates a necessary change in lenses paid at 80% of the negotiated rate;

c. Contact Lenses: Contact lenses, in lieu of eyeglass lenses and frames, once every twelve (12) months paid at 80% of the negotiated rate;

d. Eyeglass Frames: Eyeglass frames, once every twelve (12) months paid at 80% of the negotiated rate;

e. Lasik Surgery: Lasik surgery paid at 100% of the negotiated rate and subject to $1,500 per eye lifetime maximum. Not subject to the deductible or co-insurance; and

f. Safety Glasses: Prescription safety glasses for participants onlyup to two pairs every 12 months paid at 80% of the negotiated rate.

SECTION 7.02 – DEDUCTIBLE

The deductible is the out-of-pocket expense applicable to Covered Expenses incurred during any one calendar year before benefits become payable. There is no deductible for each participant for covered vision expenses incurred in a calendar year.

SECTION 7.03 – COINSURANCE PAYABLE

After the deductible has been satisfied, the Fund shall pay the following percentage of Covered Expenses incurred by each Participant:

Contract Provider:	*80% of the negotiated rates for frames/lens, contact lenses, safety glasses except lasik surgery,.*
Non-Contract Provider:	*80% of the Scheduled Allowance for except frames/lens, contact lenses, safety glasses except lasik surgery.*

SECTIONI 7.04 – EXCLUSIONS AND LIMITATIONS

No benefits are payable for:

a. Replacement of lenses and/or frames which are lost or broken except at the normal intervals when benefits for services are otherwise available;

b. Non-prescription eyeglasses, contact lenses, or sunglasses; premiums for eyeglass insurance plans;

c. Lenses secured when replacement is not deemed Medically necessary; or a second pair of eyeglasses in lieu of bifocals;

d. Medical or surgical treatment of the eyes; orthoptics or vision training;

e. Tinting of lenses unless deemed Medically Necessary by the prescribing ophthalmologist or optometrist;

f. Any optical materials that are not required to correct a visual defect;

g. Services or material for which a Participant may be compensated under any Workers' Compensation law or other employer's 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;

h. Services or materials paid by Medicare if a Participant is eligible for Medicare, whether or not enrolled in Medicare;

i. Any expense not specifically included as Covered Expenses in Section 7.01;

j. A separate charge for "contact lens fitting".

SECTION 7.05– OPTION TO DECLINE VISION COVERAGE

Under federal law, dental benefits are considered excepted benefits if either (1) vision benefits are insured and provided under separate contract, certificate or policy from the medical benefits or (2) vision benefits are not considered an integral part of a plan, if participants can elect to not enroll in dental benefits even if they do enroll in the medical plan. Excepted benefits are exempt from many of the requirements of the Affordable Care Act such as the annual and lifetime dollar limits. The Board of Trustees of the Plan believe that the dental benefits offered under this Plan are not considered an integral part of the Plan.

As such, you have the option to decline/waive the Plan's vision coverage. To decline/waive dental coverage, please complete the portion of the Plan's enrollment form related to

declining/waiving vision coverage. Enrollment forms are available from the Trust Fund Office. Please note there is no additional compensation to you if you choose to decline/waive dental coverage.

ARTICLE VIII: DENTAL CARE BENEFITS

SECTION 8.01 – DEFINITIONS

Whenever the following terms are used with initial letters capitalized, they shall have the meaning specified below.

a. "Dental Hygienist" means a person who is currently licensed to practice dental hygiene, by the governmental authority having jurisdiction over the licensing and practice of dental hygiene, and who is working under the supervision and direction of a Dentist.

b. "Dentist" (D.D.S.) means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry.

c. "Diagnostic" mean procedures to assist the Dentist in evaluating existing conditions and the dental care required. These services include (but are not limited to) examinations, x-rays and cleaning (prophylaxis).

d. "Endodontics" means procedures necessary for the treatment of non-vital teeth.

e. "Oral Surgery" means extractions and other oral surgery including pre- and post-operative care.

f. "Periodontics" means procedures necessary for the treatment of diseases of the gums and bone supporting the teeth.

g. "Prosthodontics" and "Prosthetics" means fixed bridgework, partial dentures, and complete dentures. No replacement will be made of an existing Prosthetic appliance or denture that is satisfactory or can be made satisfactory.

h. "Restorative Dentistry" means amalgam, composite, resin, porcelain, porcelain/ceramic substrate, crowns and cast restorations (when teeth cannot be restored with a filling material).

i. "Treatment Plan' means a written report by a Dentist which explains results of examination and diagnosis, and necessary treatment in the Dentist's professional judgment. Submitted treatment plans may be reviewed by the Fund's dental consultant(s), after which the participant and Dentist will be advised of covered dental expenses under the Plan. All claims not preauthorized are subject to retrospective review by the Fund's dental consultant(s).

SECTION 8.02 – COVERED DENTAL EXPENSES

A Participant may be treated by any licensed Dentist. Benefits are provided for dental care performed by a Dentist or by a Dental Hygienist under the Dentist's supervision.

a. Covered Dental Expenses are procedures and services which:

(1) Are rendered or furnished by a Dentist or Dental Hygienist, or rendered or furnished by a Physician;

(2) Demonstrate dental necessity for treatment of a dental disease, defect or Injury of a Participant. "Dental necessity" means that a service or supply meets all of the following conditions:

(A) The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis. "Appropriate" means that the type, level length of service, and setting are needed to provide safe and adequate care;

(B) It is rendered in accordance with generally accepted dental practice and professionally recognized standards;

(C) It is not treatment that is regarded as Experimental, educational, cosmetic or unproven;

(D) It is specifically allowed by the licensing statutes which apply to the provider who renders that service; and

(E) It is not primarily for the convenience of the Participant, the Participant's Dentist, or another provider.

(3) Are not specifically excluded from coverage.

b. Covered Dental Expenses are deemed to be incurred on the date the applicable dental care is received by the Participant.

c. All claims must be submitted within one year of the date the Treatment Plan is completed. Claims must show the procedure code from the ADA Current Dental Terminology and the actual charges to the Participant. Along with any necessary documentation the claim may require – such as x-rays, periodontal tooth charting, replacement information, etc.

SECTION 8.03 – ANNUAL DENTAL DEDUCTIBLE

The dental deductible is the out-of-pocket expense for Covered Dental Expenses incurred during any one calendar year before Dental Care benefits become payable. The dental deductible for each Participant is the first $100 of Covered Dental Expenses incurred per calendar year, limited to $300 per family. The deductible does not apply to routine dental examinations, prophylaxis (cleaning), or dental x-rays. You must satisfy a new dental deductible each year.

SECTION 8.04 – COINSURANCE

a. Prosthodontic Covered Services. Benefits for Prosthodontic Covered Services are as follows, after satisfaction of the deductible:

Contract Provider: *50% of the negotiated rates*
Non-Contract Provider: *50% of Covered Expenses, not to exceed the Scheduled Allowance for the dental procedures as shown in Appendix A.*

b. All Other Covered Dental Services. Benefits for all other Covered Dental Services are as follows, after satisfaction of the deductible:

Contract Provider: *95% of the negotiated rates*
Non-Contract Provider: *95% of Covered Expenses, not to exceed the Scheduled Allowance for the dental procedures as shown in Appendix A.*

SECTION 8.05 – MAXIMUM ANNUAL BENEFIT

Dental Care benefits are limited to a maximum of $2,500 per calendar year for Participants and Dependents age 19 and older. Once you meet the $2,500 maximum, the Plan will not provide any additional dental benefit during the remainder of the calendar year. Nonetheless, Dependent children up to age 19 will **not** be subject to the $2,500 calendar year maximum, including Pediatric Dental Care benefits for Dependent children through age 19.

SECTION 8.06 – SCHEDULE OF ALLOWANCES FOR DENTAL CARE

The Schedule of Allowances for Dental Care is included in these Rules and Regulations as Appendix A.

For procedures marked "B/R" (by report), the Fund will determine the allowance based upon the nature and extent of the service performed. A dental procedure of an equivalent gravity and severity listed in the schedule shall be used as the basis for the determination.

The Schedule of Allowances for Dental Care does not provide an allowance for completion of the claim form, or for broken appointments, and no payment will be made under the Plan for such charges. Allowances in all cases include local anesthesia.

With regard to services rendered by a Non-Contract Provider, when a CDT (Current Dental Terminology) Code for a particular service rendered is not listed in the Schedule of Allowances for Dental Care, Covered Dental Expenses will be based on the Contract Provider negotiated rates (PPO schedule). Provider Relations will contract a rate for the code and a new contract rate will added to the PPO contract rate for the dentist.

SECTION 8.07 – ORTHODONTIC BENEFIT

Dependent Children. Non-medically necessary Orthodontic Benefits for dependents up to age 26 are payable at 80% up to a maximum lifetime benefit of $2,500. Banding fees are limited to a maximum benefit of $500.00. There is no Deductible for this Benefit. The Plan does not cover lost, misplaced or stolen orthodontic appliances or retainers.

Adult Participants and Dependent Spouses. Orthodontic Benefits are payable at 80% up to a maximum lifetime benefit of $1,500. Banding fees are limited to a maximum benefit of $500.00. There is no Deductible for this Benefit. The Plan does not cover list, misplaced or stolen orthodontic appliances or retainers.

SECTION 8.08 – COVERED DENTAL SERVICES INCLUDING LIMITS

a. Diagnostic and Preventive dental services include:

(1) One complete full mouth series of x-rays or one panoramic x-ray once every three years. Benefits shall be limited to one complete full month series of x-rays or one panoramic x-ray, but not both;

(2) Supplementary bitewing x-rays, limited to two per calendar year, unless special need is shown;

(3) Two fluoride treatments per calendar year for dependent children under age 14;

(4) Prophylaxis (cleaning) treatment and/or oral examinations, limited to two per calendar year;

(5) Sealants are covered for dependent children under 14 years of age on molar teeth only and which have no prior restorations on the tooth and limited to a maximum of one per tooth per calendar year.

b. Basic dental services include, but are not limited to, Restorative Dentistry, Endodontics, Periodontics, and Oral Surgery procedures. Coverage limits applicable to Basic dental services are as follows:

(1) Optional Treatments. If there are optional methods of treatment, the applicable benefit for the less expensive procedure will be covered.

If a tooth can be restored with amalgam or resin-based composite, the cost of these procedures will be allowed toward any other type restoration the patient and Dentist may choose to use. The Plan will cutback fillings on posterior teeth to lower cost materials (i.e. to an amalgam filling). Posterior Porcelain/Ceramic substrate crowns will also be cutback to lower cost materials.

Night guards are covered for bruxism only.

c. Prosthodontic dental services include, but are not limited to, construction or repair of fixed bridgework, partial dentures, or complete dentures. Coverage limits applicable to Prosthodontic dental services are as follows:

(1) Benefits for Prosthodontic appliances will be provided once only in any five-year period.

(2) Optional Treatments. If there are optional methods of

treatment, the applicable benefit for the less expensive procedure will be covered under the Plan. If a cast metal framework or a resin-base partial denture restores the case, the allowance for these procedures may be applied toward a more complicated precision case the patient and Dentist may choose to use. Posterior Porcelain/Ceramic substrate bridgework will also be cutback to lower cost materials.

(3) Prosthetic services rendered or prosthetic devices furnished in connection with a dental procedure that began prior to the date eligibility terminated will be covered if expenses are incurred within 30 days following the date of termination.

(4) Repairs Relines and rebases are covered for complete and partial dentures.

d. **Dental Implants** (material implanted into or on bone or soft tissue or the removal of implants) are covered as follows:

Contract Provider	95% of negotiated rate
Non-Contract Provider	95% of covered expenses not to exceed Schedule of Allowance for Dental Procedures
Dental Benefit Maximum	$2,500 per year
Dental Deductible	$100 per year, limited to $300 per family

SECTION 8.09 – DENTAL EXCLUSIONS

No benefits are payable under the provisions of the Dental Care benefit for any of the following care, treatment, or services:

a. 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;

b. Expenses incurred which may be paid under any other benefit provided by this Fund;

c. Expenses which are due to or result from an Injury or Illness arising out of or in the course of employment, including self employment, for which the Participant is entitled to benefits under any Workers' Compensation Act or employers' liability laws; services which are provided without cost by any municipality, county or other political subdivision;

d. Any charges incurred prior to a Participant's Dental Care benefits eligibility date; any Prosthetic devices (including bridgework and crowns), and the fitting thereof, which were ordered before the Participant became eligible;

e. Expenses due to or resulting from: (1) war, act of war, armed invasion or aggression, (2) injury or disease that is intentionally self-inflicted, while sane

unless the injury results from an act of domestic violence or a medical condition such as depression; (3) nontherapeutic release of nuclear energy, (4) the Participant committing or attempting to commit a crime (no conviction is required for this exclusion to apply), or (5) employment or occupation for compensation, unless a coverage states otherwise.

f. Services to correct congenital malformations; Procedures rendered principally to improve a Participant's appearance or performed for purely cosmetic reasons; veneers, bleaching, etc.

g. Orthodontic services, including correction of malocclusion;

h. Services, appliances, or restorations necessary to alter vertical dimension or resolve the occlusion; Procedures (other than for replacement of structure loss from caries) to replace or stabilize tooth structure lost by attrition/erosion or abrasion;

i. Replacement of an existing Prosthetic device that is satisfactory or can be made satisfactory; any services for the personalization or characterization of a Prosthetic device;

j. Any charge made for completion of forms or a missed or broken appointment;

k. Replacement of an existing Prosthetic device more often than once in every five-year period;

l. Special control programs including oral hygiene and dietary instructions, dietary planning, or training in preventive dental care;

m. The replacement of a lost, misplaced, or stolen appliance before the normal prosthodontic period has passed;

n. Services performed by a relative of a Participant or by a member of a Participant's household;

o. Prescribed drugs, premedication, or analgesia when not included in the charge for a covered dental services;

p. Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services. Or for charges for general anesthesia at an outpatient surgery facility for children under the age of 6 that has been pre-approved with the pre-cert department (see additional information under the Medical Plan);

q. Any services or procedures that are experimental in nature or are not within the standards of generally accepted dental practice;

r. All hospital costs and any additional fees charged by the dentist for hospital treatment except when approved for dental services at an outpatient

surgery center (see the section under the medical benefits plan);

s. Treatment of conditions related to temporomandibular jaw joint ("TMJ") or any related TMJ services are not covered under the dental plan;

t. Any services or treatment excluded under "Covered Dental Services" above;

u. Any services or treatment excluded under "General Exclusions and Limitations";

v. Prosthodontic appliances, crowns, or bridges that were ordered while you or a covered dependent were eligible but are not installed or delivered until more than 30 days after termination of eligibility.

w. Any charges in excess of the Scheduled Allowance.

SECTION 8.10 – OPTION TO DECLINE DENTAL COVERAGE

Under federal law, dental benefits are considered excepted benefits if either (1) dental benefits are insured and provided under separate contract, certificate or policy from the medical benefits or (2) dental benefits are not considered an integral part of a plan, if participants can elect to not enroll in dental benefits even if they do enroll in the medical plan. Excepted benefits are exempt from many of the requirements of the Affordable Care Act such as the annual and lifetime dollar limits. The Board of Trustees of the Plan believe that the dental benefits offered under this Plan are not considered an integral part of the Plan.

As such, you have the option to decline/waive the Plan's dental coverage. To decline/waive dental coverage, please complete the portion of the Plan's enrollment form related to declining/waiving dental coverage. Enrollment forms are available from the Trust Fund Office. Please note there is no additional compensation to you if you choose to decline/waive dental coverage.

ARTICLE IX: DEATH AND ACCIDENTAL DEATH AND DISMEMBERMENT

SECTION 9.01 – LIFE INSURANCE BENEFIT

LIFE INSURANCE BENEFIT

PROVIDED BY THE UNION LABOR LIFE INSURANCE COMPANY FOR ACTIVE EMPLOYEES AND ELIGIBLE DEPENDENTS

For complete information regarding the Life Insurance Benefit, please contact the Trust Fund Office.

A. EMPLOYEE LIFE INSURANCE BENEFIT

Your beneficiary will receive the amount of the Life Insurance Benefit shown below in the event of your death from any cause while covered under the Plan:

Active Employee Under age 65	$3,000

If an Active Employee is not at full-time work on the date he would otherwise become insured, he will not become insured until the date he returns to active, full-time work.

B. DEPENDENT LIFE INSURANCE BENEFIT

In the event of an eligible Dependent's death from any cause while covered under the Plan, the Employee will receive the amount of the Life Insurance Benefit shown below. If the Employee is not living, Life Insurance Benefits will be paid to the estate of the deceased Dependent.

Legal Spouse	$1,000
Dependent Child:	
Up to 26 years	$1,000

C. EMPLOYEE'S LIFE INSURANCE BENEFICIARY

Your beneficiary may be any person or persons you name in your enrollment form. If you designate more than one beneficiary, benefits will be paid equally to your beneficiaries unless you specify otherwise. Your beneficiary will be the person(s) named in your most recent beneficiary designation filed with the Trust Fund Office. If you fail to name a beneficiary of if your beneficiary dies before you, benefits will be paid to the surviving person(s) in the first of the following classes: your

1. surviving spouse;
2. surviving children, in equal shares;
3. surviving parents, in equal shares;
4. surviving brothers and sisters, in equal shares; or
5. executors or administrators of the Employee's estate.

You may request a change of beneficiary at any time by submitting a new enrollment form. No beneficiary designation will be considered valid until it is received by the Trust Fund Office. You may not assign the Life Insurance Benefit.

D. EMPLOYEE'S LIFE INSURANCE BENEFIT DURING TOTAL DISABILITY

If you become Totally Disabled and are unable to perform the substantial and material duties of any gainful occupation, your Life Insurance Benefit will continue without premium payments while you are Totally Disabled if (a) the Total Disability begins while you are insured and before you reach age 60, (b) the disability has existed uninterruptedly for 9 months, and (c) you have not converted your Life Insurance Benefit. The amount of insurance will be subject to reductions based on your age. The Life Insurance Benefit provisions state that the necessary forms and written proof of Total Disability must be submitted to The Union Labor Life Insurance Company after you have been disabled for 9 months but within 1 year from the date you first became disabled. You will be required to submit evidence of your continuing Total Disability during the last 3 months of each successive one-year period of your disability.

Your coverage under this provision will end on the date you stop being Totally Disabled, fail to furnish The Union Labor Life Insurance Company proof of your Total Disability, fail to have an examination requested by pacific Life, or convert your Employee Life Insurance Benefit under the terms of this Conversion Privilege, whichever occurs first.

E. LIFE INSURANCE BENEFIT CONVERSION PRIVILEGE

If your eligibility terminated while the Master Group Insurance Policy remains in force because you no longer belong to a class of persons eligible for insurance for reasons other than (a) termination of the group policy, (b) termination of the Employee Life Insurance; or (c) your Employer ceasing to be a Contributing Employer, you may convert to an individual contract of life insurance with no evidence of insurability, provided you make a written application and pay the first premium within 31 days after coverage under the Life Insurance Benefit ceases. A person may choose any type of individual contract then being written by The Union Labor Life Insurance Company, except Term Insurance or insurance which provides disability or other supplementary benefits. The benefit amount of converted insurance may not exceed the benefit amount in force under this policy on the date your eligibility terminated.

If the Master Group Insurance Policy terminates, the Life Insurance Benefit terminates for all persons, or the Life Insurance Benefit terminates for you eligible class and you have been continuously covered for five years, you are entitled to convert to an individual contract of life insurance under the same conditions and limitations set forth in the paragraph above. However, the benefit amount cannot exceed the lesser of (a) the benefit amount available on the date of termination less any life insurance for which you are eligible or become eligible under any Group Policy within the conversion period, or (b) $2,000.

The converted life insurance policy will be in exchange for all your rights under the Master Group Insurance Policy. The premium payable for a converted life insurance policy will be based on (a) your age on the effective date of the individual policy, (b) your class risk, and (c) the form and amount of coverage to be provided.

If a person dies during the 31-day period allowed for conversion, The Union Labor Life Insurance Company will pay the Life Insurance Benefit that the person could have converted to the last beneficiary named, whether or not he has applied for conversion or paid the first premium.

If you wish to take advantage of this arrangement, contact the Trust Fund Office or write to:

The Union Labor Life Insurance Company
Attn: Group Life Claim Department
8403 Colesville Road
Silver Springs, MD 20910
Phone: (202) 682-6768
Fax: (202) 692-962-2939
Toll Free: (866) 795-0680

SECTION 9.02 – ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Provided by The Union Labor Life Insurance Company
For Active Employees Only

For complete information regarding the Accidental Death & Dismemberment Benefit, please contact the Trust Fund office.

A. THE BENEFITS

Accidental Death and Dismemberment Benefits will be paid for any of the following losses due to an Injury, **on or off the job**. For Benefits to be payable, the Injury must be sustained while you are insured and the loss must occur within 90 days after such Injury, directly and independently of all other causes. Payment will be made in addition to any other benefits you may receive.

Loss of: Life (paid to your beneficiary, in Addition to Life Insurance Benefit)	$3,000
Loss of: Two Hands, Two Feet, Sight of Two Eyes, One Hand and One Foot, One Hand and Sight of One Eye, One Foot and Sight of One Eye (paid to you)	$3,000
Loss of: One Hand or One Foot, Sight Of One Eye (paid to you)	$1,500

Loss of Hand or Foot means severance of the entire hand or foot at or above the wrist or ankle joint. Loss of Sight means total and irrecoverable loss of the sight of that eye.

B. EXCLUSIONS

No Accidental Death and Dismemberment Benefit is payable for any loss caused or contributed by:

1. Injury or disease 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. Injury or disease that results from: (a) any act of war; (b) the Employee's commission of a crime as determined by the Board of Trustees (i.e., no conviction is required); or (c) nontherapeutic release of nuclear energy;
3. Disease or mental infirmity;
4. Injury sustained in the course of any medical, dental or surgical diagnosis or treatment.

ARTICLE X: WEEKLY DISABILITY BENEFIT

SECTION 10.01 – HOW THE WEEKLY DISABILITY PLAN WORKS - The Plan will pay a Participant a weekly benefit of $200 for each 7-day week of continuous Total Disability thereafter up to maximum of 26 weeks if the Participant becomes totally disabled and unable to work while eligible for benefits under this Plan.

A. DEFINITION OF "TOTALLY DISABLED"

For purposes of this benefit, "totally disabled" means the Participant is unable, due to illness, injury or pregnancy, to perform the substantially material duties of the occupation in which he was engaged when he became so disabled and that he is not engaged in any gainful occupation.

A physician's certification of total disability is required.

B. START AND DURATION OF BENEFITS

Weekly disability benefits begin as follows:

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

Benefits will continue until the Participant is no longer disabled or he has reached the maximum of 26 weeks of continuous payments.

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

C. REPEATED INSTANCES OF DISABILITY

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

- due to unrelated causes or
- separated by a return to active full-time employment for at least two consecutive weeks

D. INJURIES COVERED BY WORKERS' COMPENSATION

If your disability is the result of an occupational injury covered by Workers' Compensation Temporary Disability benefits, the Fund's weekly disability benefit will be reduced by any amount payable under the Worker's Compensation benefits. The Plan may request that you reimburse the Plan for any such payment received (or entitled to receive). The Plan may offset said amounts against any other Plan benefits provided under the Plan.

SECTION 10.02 – EXCLUSIONS FROM COVERAGE

A. No Benefits are payable for the following disabilities:

1. A disability that began before you became eligible for benefits under the Fund.

2. Any bodily illness or injury for which evidence is not furnished to the Fund that you are totally disabled.

3. Any disability suffered by your spouse or dependent children (weekly disability benefits cover employees only).

B. No Benefits are payable under the following circumstances:

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

2. Once you are receiving or are entitled to Social Security benefits.

3. Once you are receiving pension benefits or have attained age 62 whichever occurs first.

SECTION 10.03 – HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

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

- Obtain a Statement of Claim for Accident and Sickness Weekly Benefits from the Administrative office.
- Complete the active employee's portion of the claim form.
- Have your physician complete the attending physician's portion of the claim form.
- Check the claim form to be certain that all applicable portions of the form are completed. By doing so, you will speed the processing of your claim.
- Mail the claim form to U.A. Local 350 Health, Welfare & Vacation Trust Fund, P.O. Box 11337, Reno, Nevada 89510.

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

If you disagree with the decision made on your claim, you may appeal the decision.

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

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

Keep this Notice with your Health and Welfare Plan booklet. If you have any questions about these changes to your Health & Welfare Plan, contact the Trust Fund Office at (775) 826-7200.

ARTICLE XI: U.A. LOCAL UNION NO. 350 VACATION PLAN

This Plan provides "Vacation" benefits to employees working under a Collective Bargaining Agreement with U.A. Local 350 for whom contributions are made on their behalf to this Plan.

The Board of Trustees has contracted with the Operating Engineers Local Union No. 3 Federal Credit Union to maintain individual Vacation Accounts for U.A. Local 350 members. You are required to become a member of the Credit Union in order to receive your Vacation funds.

The Plan transfers the employer contributions to your Individual Account at the Credit Union on or about the 10th day of the month based on work performed two months before. By way of example, the employer contributions made to the Plan for hours you worked in October, which

are contributed in late November usually, will be deposited into the Vacation Account on or around December 10. If the 10th day of the month falls on a weekend or holiday, the transfer may not take place until the first business day that follows. If your employer fails to make the required contributions, the Vacation funds will **NOT** be transferred to your Vacation Account.

If you have any questions about your Vacation benefits, you may contact the Credit Union as follows:

Operating Engineers Local 3 Federal Credit Union
1290 Corporate Blvd.
Reno, Nevada 89502
(800) 877-444

You have to follow the rules of the Credit Union, including any minimum balance requirements to maintain an account and any fee that the Credit Union may charge. Earnings on your Vacation Account will be as determined by the Credit Union based on the rates then in effect.

Any fund remaining in your Vacation Account with the Credit Union at the time of your death will be distributed in accordance with the rules of the Credit Union.

You may authorize a deduction from your Vacation Account for Union dues and related charges. **IMPORTANT: Vacation pay on deposit at the Credit Union that is not accessed at least onetime within a 12-month period becomes "dormant' and subject to escheatment. All accounts that do not have a member contact in a 3 or more year period will revert to the Trust Fund. If you've worked under a labor agreement that was eligible for vacation pay but never accessed your vacation account, please contact the Credit Union. If you access your account on a regular basis (or at least once per year), the reversion to the Trust Fund does not apply and no action is necessary on your part.**

ARTICLE XII: GENERAL PROVISIONS

SECTION 12.01 - NO ASSIGNMENT OF BENEFITS - The benefits payable hereunder shall not be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge or garnishment. There is no assignment of benefits to providers and no benefit payments may be paid to providers.

SECTION 12.02 - 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 12.03 - 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 12.04 - 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 12.05 - 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.

SECTION 12.06 - 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 12.07 - 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 12.08 - 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 12.09 - 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 12.10 - THIRD PARTY RECOVERY/SUBROGATION/REIMBURSEMENT REQUIREMENTS - If the Covered Person is injured through the act or omission of another party, Plan benefits are available provided all of the following are met:

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

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

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

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

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

10. The Plan is entitled to a first priority and first-dollar basis recovery for the full amount of Covered Charge it has paid or may pay for the injury or illness of a Covered Person that are related to the Third Party Claim from any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether the claimant is made whole and regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

11. As a condition of receiving benefits under the Plan, the Covered Person grants specific and first rights of subrogation, reimbursement and restitution to the Plan. Such rights shall

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

12. Such reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits. Without in any way limiting the preceding, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action, or rights that the Covered Person has or that may arise against any person, corporation, and/or other entity who has or who may have caused, contributed to and/or aggravated the injury or condition for which the Covered Person claims an entitlement to benefits under the Plan, and to any claims, causes of action, or rights the Covered Person may have against any other no-fault coverage, uninsured and/or underinsured motorist coverage, or any other insurance coverage or fund.

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

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

15. 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.

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

17. 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.

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

SECTION 12.11 - ERISA - The Plan of benefits created herein is an "Employee Welfare Plan" under the Employee Retirement Income Security Act of 1974 as amended.

SECTION 12.12 - PARTICIPANT ON ACTIVE MILITARY SERVICE:

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

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

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

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

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

   c. Assert Military Rights for no More than Five Years (with certain exceptions). You may assert USERRA benefits for military absence not to exceed

five years. There are limited exceptions to the five-year rule so if you are close to that period, you may contact the Trust Fund Office to determine if your situation may meet an exception to the five-year rule.

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

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

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

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

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

3. Right to Certain Health Care Benefits Under the Plan

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

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

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

Employment (with proper notice and documentation), your Hour Bank will be reinstated in accordance with the Plan rules.

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

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

YOU MUST NOTIFY THE TRUST FUND OFFICE OF YOUR RETURN FROM ACTIVE DUTY. Participants must notify the Trust Fund Office of their return from active duty. The Trust Fund Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

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

SECTION 12.13 – PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 [HIPAA]

1. INTRODUCTION.

The U.A. Local 350 Health, Welfare, and Vacation Plan ("Plan") is required by state and federal law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information, known as Protected Health Information ("PHI") that identifies you is kept private and secure to the extent required by law. We are also required to give you this Notice regarding the uses and disclosures of medical information that may be made by the Plan, and your rights and the Plan's legal duties with respect to such information. The Plan must also follow the duties and privacy practices described in this Notice. This Notice and its contents are intended to conform to the requirements of HIPAA, and it applies to all records containing your PHI that are created, transmitted or retained by the Plan or Business Associates (including their subcontractors) that help administer the Plan.

- **PHI Defined.** The term "PHI" or "medical information" in this Notice means individually identifiable medical and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.
- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.
- **Minimum Necessary.** When using or disclosing PHI, the Plan will make reasonable efforts not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological factors and limitations and any applicable law requiring greater disclosure.

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

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

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

For more information please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

2. POTENTIAL IMPACT OF STATE LAWS.

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproduction rights, and so on.

3. BOARD OF TRUSTEES' OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION

The Board of Trustees Will:

a. Prohibit Use and Disclosure of Protected Health Information. Not use or disclose your Protected Health Information except as permitted by the benefit booklet as amended from time to time or required by law.
b. Subcontractors and Agents. Ensure that any agent or subcontractor to whom the Board of Trustees provides your Protected Health Information agree to the restrictions and conditions in the benefit booklet including this
section, with respect to your Protected Health Information.
c. Permitted Purposes. Not use or disclose your Protected Health Information for employment-related actions or decisions in connection with any other benefit or employee benefit plan sponsored by the Board of Trustees.
d. Reporting. Report to the Plan's privacy officer any use or disclosure of your Protected Health Information that is
inconsistent with the uses and disclosures allowed under this section promptly upon learning of such inconsistent use or disclosure.
e. Access to Protected Health Information by Participants. Make your Protected Health Information available to you in accordance with 45 C.F.R. § 164.524.
f. Amendment of Protected Health Information. Make your Protected Health Information available for amendment and, upon request, amend your
Protected Health Information in accordance with 45 C.F.R. § 164.526.
g. Accounting of Protected Health Information Disclosures. Track disclosures made of your Protected Health Information so that an accounting of disclosures can be made available to you upon request in accordance with 45 C.F.R. § 164.528.
h. Disclosure to Governmental Agencies. Make available the Plan's internal practices, books and records relating to the use and disclosure of your Protected Health Information to the United States Department of Health and Human Services to determine compliance with 45 C.F.R. § 164.
i. Return or Destruction of Protected Health Information. When your Protected Health Information is no longer needed for the purpose for which use or disclosure was made, the Board of

Trustees must, if feasible, return to the Plan, or destroy, all Protected Health Information that the Board of Trustees received from or on behalf of the Plan.
This includes all copies in any form, including any compilations derived from the Protected Health Information. If return or destruction is not feasible, the Board of Trustees agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
j. Minimum Necessary Requests. Use their best efforts to request only the minimum necessary type and amount of your Protected Health Information to carry out the functions for which the information is requested.

4. ADEQUATE SEPARATION BETWEEN THE BOARD OF TRUSTEES AND THE PLAN

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

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

provided the Business Associate has signed a Business Associate Agreement.

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

5. ADEQUATE SEPARATION CERTIFICATE

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

6. Privacy Practices of the U.A. Local 350 Health,Welfare and Vacation Plan

How do we typically use or share your medical information?

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

Treatment.	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. *Example: Doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
For Payment.	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from

	health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. *Example: We share your eligibility for benefits information with a Health Care Provider to confirm whether payment will be made for a particular service.*
For Health Care Operations/Appeals.	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal. *Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.*
As Required By Law.	The Plan can use and disclose your health information if required by state, federal or local laws. *Example: We share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues.	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability. *Example: We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits.	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. *Example: We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*
Disclosure to Health Plan Sponsor & U.A. Local Unions.	Medical information may be disclosed to the Plan Sponsors, i.e. U.A. Local 350, and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.
Organ and Tissue Donation.	The Plan can share health information about you with organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
Military, Veterans, and Inmates.	The Plan may release health information about you as required by military command authorities, if you are a member of the armed forces, or to a correctional institute or law enforcement official, if you are an inmate or under custody of a law enforcement official.
Respond to Lawsuits and Disputes.	Th The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. *Example: We receive a discovery request in which you are a party involved in a lawsuit.*
Government or Law Enforcement Requests.	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement official or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims. *Example: We release health information because there is suspicion that your death was the result of a criminal conduct, or because of civil administrative or criminal investigations, audits, inspections, licensure or disciplinary action, or other activities necessary for the government to monitor government programs (such as Medicare fraud review), or for special government functions such as military, national security and presidential protective services.*
Research.	The Plan can use and share your health information for health research subject to certain conditions.
Child Immunization	The Plan may disclose proof of immunization of a student to the School, prior to

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

Our Uses and Disclosures

For certain information, you can tell us your choices about what we share.

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

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

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

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

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

- ✓ **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- ✓ **Marketing Authorization**. The Plan cannot receive financial remuneration (direct or indirect payment) from third parties in exchange for the marketing of PHI unless permitted under HIPAA or with your prior written authorization. Marketing is any communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This Plan never markets personal information.
- ✓ **Sale of PHI.** The Plan is prohibited from directly or indirectly receiving financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell your PHI.
- ✓ **Fundraising Purposes**. Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. Although the Plan does not use nor does it intend to use your PHI for fundraising purposes, it must inform you of your right to opt out of receiving any fundraising

communications (whether received in writing or over the phone) if it uses or discloses your PHI for fundraising purposes.

- ✓ **Genetic Information.** Your PHI includes genetic information. In regards to underwriting, which is premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008. Also, the Plan cannot use your genetic information to decide whether it will give you coverage and the price of that coverage.
- ✓ **Other Uses of Medical Information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your Rights

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

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

- ✓ **Right to Inspect and Copy Your Medical Information.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Trust Fund Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

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

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

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

  To request an accounting of disclosures, you must submit your request in writing to the Trust Fund Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

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

- ✓ **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us you would be in danger if the Trust Fund office does not honor your request. To request confidential communications, you must make your request in writing to the Trust Fund Office. Your request must specify how or where you wish to be contacted.

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

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

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

- ✓ **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice).** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy

rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

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

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

Changes to This Notice

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

Requests for Information

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

U.A. Local 350 Health, Welfare, and Vacation Fund
c/o Benefit Plan Administrators Inc.
445 Apple Street
Reno, Nevada 89502
Telephone: (775) 826-7200
Website: https://350plumbers.com

SECTION 12.14 – FAMILY MEDICAL LEAVE ACT--EMPLOYEES OF LARGER EMPLOYERS:

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

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

c. You require leave for one of the following reasons:

i. birth (within one year of birth) or placement of a child for adoption or foster care (within one year of placement),
ii. to care for your child, spouse or parent with a serious medical condition, or
iii. your own serious health condition,
iv. Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). Care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness; or
v. Any other purpose provided for by the FMLA as amended.

You must intend to return to work for your employer after the FMLA and you may use the FMLA benefit once per 12 consecutive months. Details concerning FMLA leave are available from your Employer.

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

SECTION 12.15 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS/NATIONAL MEDICAL SUPPORT NOTICES

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

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

(b) enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the Employee parent does not enroll the child, then the non-Employee parent or State agency may enroll the child.

A QMCSO may be either a National Medical Child Support Notice ("NMSN") issued by a state child support agency or an order or a judgment from a state court or administrative body directing the employer/plan to cover a child under the Plan. Federal law requires that a medical child support order meet certain form and content requirements in order to be qualified. You may request a copy of the written procedure for determining whether a

medical child support order is qualified, free of charge, from the Plan Manager. In general, the following steps will be followed to establish and determine whether a court order or NMSN will qualify as a QMCSO:

(a) The participant must provide the Trust Fund Office with a copy of the court order or NMSN and/or QMCSO;
(b) Within 30 days of receipt of the QMCSO and/or NMSN, the Trust Fund office or the Plan's Legal Counsel will notify the Participant in writing if the order is acceptable to the Plan;
(c) If the Plan determines the court order or NMSN and/or QMCSO is not acceptable or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's Legal Counsel;
(d) **If a QMCSO and/or NMSN is denied**. The notice will describe the reasons for denial and your right to appeal, along with a summary of the Plan's appeal procedures. In most instances however, you will simply be asked to revise the order in such a way that it is a QMCSO and/or qualified NMSN.
(e) **If additional information is required**. The notice will describe what is needed. There will
be sixty (60) days to respond.
(f) To be Qualified, a Medical Child Support Order must clearly specify:
- the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such child,
- the period of coverage to which the Order applies, and
- the name of each Plan to which the Order applies.

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

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

No eligible Participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

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

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

SECTION 12.16 – THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours

following a vaginal delivery, or less than 96 hours following a cesarean delivery.

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

SECTION 12.17 – THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services for eligible participants and dependents. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- All stages of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);
- Surgery and reconstruction to achieve symmetry between the breasts;
- Prostheses, and
- Physical complications resulting from all stages of a mastectomy (including lymphedema).

Call the Trust Fund Office for more information.

SECTION 12.18 – CHANGES ALLOWED UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

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

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

In both cases, you must request special enrollment within 60 days (of the loss of Medicaid/SHIP or the eligibility determination.

SECTION 12.19 – CLAIM FORMS

All claims for benefits shall be filed on forms provided by the Plan, which will be available from the Trust Fund Office. The Plan, upon receipt of a written notice of claim, will furnish such

forms to the claimants.

SECTION 12.20 – 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 Trust Fund Office, provided the claim is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as possible of what is necessary to complete the claim. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if the Trustees determine it was not reasonably possible to give proof within such time, provided, except in the absence of the claimant's legal capacity, it is later than one year from the time proof is otherwise required.

SECTION 12.21 – 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 12.22 – 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 12.23 - CONSTRUCTION

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

SECTION 12.24 – 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 12.25 – FACILITY OF PAYMENT

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor or, if there is no such guardian, to such adult or adults as have complied with the requirements of Nevada or other applicable law for receipt of such benefit on behalf of the minor, after which the

Plan shall have no further obligations with respect to such minor.

SECTION 12.26 – 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 12.27 – GENDER AND NUMBER

Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

SECTION 12.28 – OVERPAYMENTS; DUTY OF COOPERATION

Whenever a payment or payments are made in excess of the allowable amount payable under the Plan, the Fund has the right to recover such excess payments from any person(s), service plan or any other organization to or for which the excess payments were made.

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

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

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

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

SECTION 12.29 – PATIENT PROTECTION AND AFFORDABLE CARE ACT (“ACA”)

1. **Grandfathered Plan.** The Board of Trustees believes this Plan is a "Grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. Grandfathered health plans must comply, however, with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit ***www. Healthcare.gov/glossary/essential-health-benefits***).

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

1. **No Pre-Existing Condition Exclusions for Any Individual.** The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions.

2. **Dependent Child(ren) Coverage Up to Age 26.** In accordance with the ACA, the Plan will permit a Participant's eligible Child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the Child(ren) attains age 26, regardless of whether the Child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her Spouse's plan) and regardless of the Child(ren)'s marital status, student status, financial dependency, residency, or employment status.

3. **Minimum Essential Coverage.** Under the ACA, Plan sponsors are required to provide minimum essential coverage. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

4. **Availability of Summary of Benefits & Coverage ("SBC").** The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge. If you want a copy of the Plan's self-funded Plan SBC, please call the Trust Fund Office.

5. **Elimination of Lifetime and Annual Dollar Limits on Essential Health Benefits.** The

ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion.

6. **Prohibition on Rescissions of Coverage.** Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or your and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

7. **For More Health Care Reform Information.** Please visit the U.S. Department of Labor website at *www.dol.gov/ebsa/healthreform* for more information about the ACA's provisions.

SECTION 12.30 – MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA).

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa*.

ARTICLE XIII: COORDINATION OF BENEFITS (COB)

All benefits of this Plan are subject to Coordination of Benefits (COB) and benefits are coordinated when you and your spouse (and/or your dependent children) are eligible for benefits from both this Plan and another group health plan (usually your spouse's plan). Coordination allows benefits to be paid by two or more plans up to but not to exceed 100% of the allowable expenses on the claim.

COB payment amounts shall not exceed the contracted maximums of the contract providers. At no time will the Plan pay more than for what the Participant is financially responsible.

SECTION 13.01 - 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, prescription drug and dental benefits—it does not apply to vision benefits, Life Insurance, AD&D Insurance or Weekly Disability Benefits.

2. Sharing of Information. The Fund Office may release or receive necessary information about your claim to or from other sources. You must furnish the Fund Office with any information it needs to process your claim.

3. Claim Filing Requirement. You must file a claim for any benefits you are entitled to from any other source. Regardless of whether you file a claim with these other sources, the benefits payable by this Plan will be calculated as though you have received any benefits you are entitled to from the other source(s).

4. Other Group Plans. Benefits are coordinated with other group plans, including group Blue Cross and Blue Shield plans, motor vehicle insurance, and blanket insurance plans. If you or your spouse are covered under another plan, you can contact the Trust Fund Office to find out whether that plan fits the definition of a group plan.

5. Medicare. Benefits are also coordinated with Medicare. If a person is eligible for Medicare, this Plan's benefits will be calculated as though he is enrolled in both Part A and Part B of Medicare, even if he has not actually enrolled in both Parts. (See Section 13.05 for more detail.)

6. File Claims with Other Plans Too. When anyone in your family is covered under another group health plan and has a claim, be sure that you file claims with all eligible plans and provide all required information about other coverage on all claim forms.

7. Failure to Take Action. If a person is covered under one or more other plans in addition to this Plan, this Plan will coordinate benefits on the assumption that the other plans' rules were followed, that required providers were used, and that the other plans' maximum benefits were paid. This Plan will not pay benefits for expenses which would have been covered by another plan but which are not covered by the other plan because the person failed to take the action required under the other plan's rules. This could occur in a case where the person was required by the other plan to use certain doctors or hospitals under an HMO or PPO plan. Or it could occur in cases where the person failed to comply with the other plan's required utilization review or cost containment procedures, such as hospital preadmission review, second surgical opinions, certification of other types of treatment, or any other required notification or procedure of the other plan, including failing to file a claim on time. It is important that you timely notify the Trust Fund Office if you have other coverage whether individual or group health coverage. Generally, the Trust Fund Office sends annual requests for Other Insurance forms but if you do not send you and/or your eligible dependent's information regarding other available insurance coverage within 180 days of the date of service for a claim, the claim could be denied.

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 13.02 - 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 13.03 - 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 13.04 - 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. DEPENDENT CHILD - PARENTS NOT SEPARATED OR DIVORED (Birthday rule). Except as stated in Paragraph 3 below, when this Plan and another Plan cover the same child as a Dependent of different persons the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   If, however, another Plan does not have the rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. NATURAL DEPENDENT CHILD - SEPARATED OR DIVORCED PARENTS. If two or more Plans cover a Dependent child of divorced or separated parents or parents not living together, benefits for the child are determined in this order:

   a. first, the Plan of the natural parent with custody of the child;
   b. then, the Plan of the spouse (if any) of the parent with custody of the child;
   c. the Plan of the natural parent not having custody of the child;
   d. the Plan of the spouse (if any) of the non-custodial parent.

   If there is joint physical custody of the children, without the Court stating that one parent must be "primary," but the Court uses words like "maintain or carry insurance," then the Plan that has been in effect longer is the primary plan.

   If, however, the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or coverage, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. (Primary)

4. OTHER DEPENDENT CHILDREN. This Plan shall always pay secondary to any other group type coverage.

5. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

6. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determines the order of benefits, the benefits of the Plan that covered the person (for whom the claim is filed) for the longest period will pay first.

7. DEPENDENTS OF DECEASED ACTIVE EMPLOYEES. This Plan shall always pay secondary to any other group type coverage.

SECTION 13.05 – COORDINATE WITH MEDICARE

1. EMPLOYEES CONTINUING TO WORK AFTER AGE 65. If you continue to work for a contributing employer after you become age 65 and eligible for Medicare, you are entitled to the same benefits as employees under age 65 as long as you meet the regular eligibility rules. This Plan will be your primary provider of health care benefits unless it is legally permitted to pay second. Medicare will pay secondary benefits only for expenses covered by it and which are not paid by the Plan.

   If your dependent spouse is age 65 or older and eligible for Medicare while you are still working and eligible (regardless of your age), this Plan will usually pay its normal benefits for her before Medicare pays unless it is legally permitted to pay second. If she is covered under her own plan, her plan will pay first, this Plan will usually pay second, and Medicare will pay last.

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

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

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

3. MEDICARE-ELIGIBLE PERSONS UNDER 65. If any covered person is entitled to Medicare for reasons other than being 65 or older (for example, because of disability or being an End Stage Renal Disease beneficiary), this Plan will usually pay its benefits on that person's claims before Medicare pays its benefits unless it is legally permitted to pay second. This provision doesn't apply to retirees or their dependents.

4. ALL MEDICARE-ELIGIBLES AGE 65 OR OVER. Persons age 65 or older are also entitled to select Medicare as their coverage. To do so, they must decline all coverage under this Plan.

Contact your local Social Security Administration office if you have any questions about Medicare enrollment or eligibility.

SECTION 13.06 - 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 13.07 - 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 XIV: CLAIMS AND APPEAL PROCEDURE

The following procedures apply to the Eligibility Provisions and Indemnity Plan Benefits included in this booklet. They also apply to Dental, Vision & Life Insurance claims only after the Member has exhausted the appeal procedures that are available through the respective carriers. For HMO, Dental, Vision, Life Insurance or AD&D Claims, please refer to the claims procedures in the Supplemental Summaries available in the Trust Fund Office. The Board of Trustees has established the claims and appeals procedures with the intent of comply with the regulations issued by the U.S. Department of Labor.

A. HOW TO FILE A CLAIM

Claims are paid in accordance with bills and forms supplied by hospitals and attending physicians. A claim shall be considered to have been filed as soon as it is received by the Trust Fund Office at its principal office, provided it is substantially complete, with all necessary documentation. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim. **All claims for benefits must be filed within 12 months from the date of treatment or service.** Failure to do so will result in non-payment. Have your Physician forward claims directly to the Trust Fund Office. It is your responsibility to ensure that proofs of claims are timely filed with the Trust Fund Office.

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

B. CLAIMS AND APPEALS PROCEDURES

1. DEFINITIONS.

a) Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in

whole or in part) for a service, supply or benefit under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(1) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);

(2) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(3) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not Medically Appropriate;

(4) a restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and

(5) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

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

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

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

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

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

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

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

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

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

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

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

2. NOTICE OF CLAIM DENIAL

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

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

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent Plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

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

c) Urgent Care: In the event the claim involves "urgent care," which is defined as

any claim for medical care or treatment which in your physician's opinion is required immediately to avoid jeopardizing your life, health or ability to regain maximum function, you will be notified within twenty-four (24) hours of the submission of the claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours in the event coverage is denied.

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

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

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

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

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

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

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

If the Plan determines that additional information is required from the Participant, and the

Participant fails to provide any requested information within 45 days, the Plan will issue a Notice of Adverse Benefit Determination.

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

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

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

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

Effective January 1, 2018, for an Adverse Benefit Determination on disability claims, the Content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based;
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);
3. Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
6. Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;
7. Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered, as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and
8. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-english language spoken where you live.

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

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

i) Temporary Claims Filing Emergency Rules During Public Health Emergency. Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, any benefit claims filing requirements (including 1-year period to file suit), for claims **as of March 1, 2020**, has been temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those claims received/processed earlier than March 1, 2020, any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your claims filing deadline but the days that fall within the Outbreak Period will be temporarily tolled pursuant to federal guidance. **Please contact the Trust fund Office to determine your individualized situation.**

3. APPEAL PROCEDURES.

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

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

a. Calling the Trust Fund Office and asking to speak to the Utilization Review Representative. All oral requests must be

followed by a faxed written request within 24 hours.

b. Faxing the request to the attention of the Utilization Review Representative.

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

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

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

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

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

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

(3) Post-Service and Disability Claims. Ordinarily, decisions on appeals

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

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

Effective January 1, 2018, for Notice of denial of an appeal for Disability claims, the content of the Notice will include (if applicable):

1. Reference to the specific Plan provision(s) on which the determination is based;
2. Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of

any disability determination made by the Social Security Administration (if applicable);

3. Statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;
4. Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;
5. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;
6. Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit; and
7. If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-english language spoken where you live.

e. 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.

(1) Statute of Limitation for Lawsuits. No Employee, Dependent, Beneficiary or other person

shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has **one** year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. In addition, a Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

This one year limitation period covers any and all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

Effective January 1, 2018, however, if the Plan has failed to comply with the claims and appeals procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a disability claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.
Pursuant to Federal Emergency Rules, effective immediately and only during the public health emergency, the Plan will disregard the period from March 1, 2020 until 60 days after the announced end of the national emergency or such other date announced by the federal agencies (known as the "Outbreak Period") for filing a lawsuit. This means any right to file suit from the date you receive a denial of an appeal or adverse action as of March 1, 2020 will be temporarily delayed and counted from the end of the Outbreak Period.

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

(2) Venue Restrictions. Effective January 1, 2021, any claim that you, your authorized representative, or your eligible dependent(s) may have relating to or arising under the Plan may only be brought in the U.S. District Court for the District of Nevada. No other court is a proper venue or forum for you, your authorized representative or eligible dependent's claim. The U.S. District Court for the District of Nevada will have personal jurisdiction over you and any other participant or beneficiary named in the action.

(3) Class Action Waiver. Effective January 1, 2021, the Plan and the Participants and Dependents agree that all Claims pursued against each other will be on an individual basis. To that end, the Participants and Dependents hereby waive their right to commence, to become a party to, or to remain a participant in, any group, representative, class, collective, or hybrid class/collective action in any court, arbitration proceeding, or any other forum, against the other.

g. Temporary Appeals Filing Emergency Rule During Public Health Emergency.

For those claimants (or their authorized representatives) who received an adverse benefit determination/claims denial **as of March 1, 2020** the claimant (or authorized representative's) right to file an appeal within 180 days for health & welfare and disability-related claims has been temporarily tolled and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2)the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those claimants who received an adverse benefit determination earlier than March 1, 2020 any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your appeals filing deadline but the days that fall within the Outbreak Period will be temporarily tolled and pursuant to federal guidance. **Please contact the Trust fund Office to determine your individualized situation.**

ARTICLE XV: POTENTIAL LOSS OF BENEFITS

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

A. Exclusions/Co-Payments. The various plans and insurance policies contain exclusions that may preclude you from having coverage. You are also responsible for co-payments in most situations.

B. Ineligible. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

C. Not Timely. The claim wasn't filed within the Plan time limits.

D. Not Covered or Not Incurred. The expenses that were denied are not covered under the Plan or were not actually incurred.

E. Full Benefit Provided. The person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.

F. Plan Change. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.

G. Recover Overpayment. The Trustees reduced or temporarily suspended future benefit payments to a family member in order to recover an overpayment of benefits previously made on that person's behalf or on behalf of another member of the same family.

H. Fail to File Complete Application Benefits may not be payable until a completed application and other required forms and information is received by the Trust Fund Office.

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

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on

such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

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

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

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

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

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

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

P. Prohibited Employment in the 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 XVI: 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 Health and Welfare 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 XVII: ADDITIONAL INFORMATION REQUIRED BY ERISA

A. NAME AND TYPE OF PLAN

The name of the Plan is the U.A. Local 350 Health Welfare and Vacation 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 Inc.to be the Fund Manager for the Plan. You may contact the Plan as follows:

Fund Manager
U.A. Local 350
Health & Welfare Plan
445 Apple Street
P.O. Box 11337
Reno, Nevada 89502

C. PLAN SPONSOR

The Plan is sponsored by a joint labor-management Board of Trustees, the name and address of

which is:

Board of Trustees of the U.A. Local 350 Health, Welfare, and Vacation Plan
445 Apple Street
Reno, Nevada 89510

D. 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.

E. PLAN YEAR

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

F. EMPLOYER IDENTIFICATION NUMBER

The Internal Revenue Service Employer Identification Number (EIN) for this Plan is 88-0101307. The Plan Identification Number is 501.

G. FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with Collective Bargaining Agreements between the U.A. Local 350 and certain designated Employer associations (and some individual Employers), which require Employers to contribute to the Plan. The hourly contribution rate is specified in the applicable collective bargaining agreement. Copies of the collective bargaining agreement can be obtained from the U.A. Local 350 union office.

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

H. FUND MEDIUM

Assets of the Plan are held in Trust are held in custody of U.S. Bank. The Board of Trustees has retained ANDCO Investments as the Plan's Investment Consultant. The Board of Trustees may select other Investment Consultants in the future. The Board of Trustees makes the investment decisions to the Plan Assets.

I. SOURCE OF CONTRIBUTIONS

The Plan is funded through employer contributions the amount of which is specified in the applicable Collection Bargaining Agreement or the amount specified by the Board of Trustees for non-bargaining unit employees. Also, self-payments by employees or dependents are permitted as outlined in this booklet. The amount of self-payments are established from time to time by the Board of Trustees.

J. STATEMENT OF ERISA RIGHTS

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

(1) RIGHT TO RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS

a. Examine without charge at the Trust Fund Office and at other specified locations such as worksites and the Union office, documents governing the Plan, including Collective Bargaining Agreements, insurance contracts (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Department of Labor (and which is also available at the Public Disclosure room of the Department of Labor's Employee Benefits Security Administration ("EBSA") office.

b. Obtain copies of Plan documents governing the operation of the Plan (ex. Updated Summary Plan Description, Collective Bargaining Agreements, Copies of the latest annual report, insurance contracts) upon written request to the Plan. Pursuant to ERISA, the Trust Fund Office may require that you pay a reasonable charge for the copies.

c. Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with a copy of this SAR.

d. Continue health coverage for yourself, eligible spouse or dependent child(ren) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this booklet for the rules governing COBRA continuation coverage rights.

(2) PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for operating the Plan. The people who operate your Plan, called

"fiduciaries," have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your Union, or any other person or entity, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

(3) 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 know why this was done, to obtain copies of applicable documents relating to the decision, and to have the Plan review and reconsider your claim, without charge and all with certain time limits.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan such as certain Plan documents or the latest annual report (Form 5500) and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $112 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator or the Plan's delegate's control.

If you have a claim for benefits which is denied or ignored in whole or in part, and which is upheld on appeal (or ignored), you may also file a lawsuit. **Under the Plan, you are required to file a lawsuit within one year after your appeal has been denied or other action, omission or decision which adversely affected you or your dependent's benefits**. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.

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

If you file a lawsuit, the court will decide who should pay court costs and legal fees to. If you are successful, the court may order the person(s) you have sued to pay your costs and fees to the prevailing party. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees (e.g., your claim was frivolous). **Again, no lawsuit may be filed more than one year after services were provided or benefits were partially or totally denied, or an otherwise adverse benefit determination was made against you.**

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

If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents from the Plan Administrator, you should contact Employee Benefits Security Administration (EBSA), U.S. Department of Labor at EBSA's toll free number at 866-444-3272 or electronically at www.askebsa.dol.gov. or write to the Department's national office at the following address:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you. You may find answers to your questions and a list of EBSA offices at: **http://www.dol.gov/ebsa/welcome.html**.

ADOPTION BY THE BOARD OF TRUSTEES

IN WITNESS WHEREOF, the Trustees have caused this Plan to be restated and adopted as of October 1, 2021.

Employer Chair

Labor Co-Chair

U.A. LOCAL 350 HEALTH, WELFARE & VACATION PLAN