Northern Nevada Operating Engineers Health and Welfare Trust Fund

Health Care and Insurance Benefits for Active Employees and their Eligible Dependents

March 1, 2006

NORTHERN NEVADA OPERATING ENGINEERS
HEALTH AND WELFARE TRUST FUND

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TO ALL ELIGIBLE EMPLOYEES:

We are pleased to provide you with this booklet describing your health care and insurance benefits under the Northern Nevada Operating Engineers Health and Welfare Trust Fund as of March 1, 2005.

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

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

Summary Plan Description

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

About Your Benefits

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

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

Questions?

We encourage you to read this booklet carefully and keep it handy for future reference. If you are married, please share the booklet with your family.

If you have questions about your benefits, contact the Administrative Office at the address or telephone number above. You should understand, however, that only the full Board of Trustees is authorized to interpret the benefits described in this booklet and that this authority cannot be delegated to Administrative Office staff. In addition, no employer or union, or any representative of any employer or union, is authorized to interpret this Plan on behalf of the Board of Trustees or act as an agent of the Board of Trustees.

Sincerely,
BOARD OF TRUSTEES

CONTENTS

Chapter 1

OVERVIEW

In this chapter you'll find:

- An overview of your benefits
- Information on filing claims
- Contact information

Plan benefits are summarized in the chart below.

Overview of Benefits for Eligible Employees		
Benefit	**Who Can Be Covered**	**Description**
Comprehensive Major Medical	You and your eligible dependents	Up to $1,000,000 in lifetime hospital and outpatient benefits per person. Has a Contract Provider feature that allows you to keep your share of the costs down.
Prescription Drug	You and your eligible dependents	Covers the cost of generic and brand name prescription drugs after you pay $10, $20, or $25 per prescription when you use a contracted pharmacy. Also offers a mail order service for maintenance drugs at a reduced cost.
Dental	You and your eligible dependents	Up to $2,500 per year in preventive, basic, and major dental services per person. Has a Contract Provider feature that allows you to keep your share of the costs down.
Orthodontia	Your eligible dependents to age 19	$2,500 lifetime maximum at 100%.
Vision Care	You and your eligible dependents	Provides you with reimbursements toward the cost of eye exams and glasses or contact lenses. Has a Contract Provider feature that allows you to reduce or eliminate your share of the costs.
Medicare Premium Reimbursement	You and your spouse	Reimburses you for 100% of the Medicare Part B premiums.
Weekly Disability	You	Helps replace lost income when you are disabled, paying $200 per week for up to 26 weeks. Benefits begin the first day for a disability caused by an accidental injury or on the 8th day for a disability caused by illness.
Employee Life Insurance	You	$10,000 coverage.
Dependent Life Insurance	Your eligible dependents	$1,000 coverage for your spouse. Lower coverage amounts for your dependent children.
Accidental Death and Dismemberment Insurance	You	Benefit of $1,250 to $5,000, depending on the nature of the loss.
Burial Expense	You (*the benefit is paid to your survivors*)	$2,500 benefit.

More detailed information, including charts showing covered service or losses, can be found in the chapters describing the individual benefits. Also see chapter 13, "Other Important Plan Information," for general provisions regarding your benefits.

Unfamiliar Term?

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

FILING CLAIMS

Information on how to file claims is included at the end of each of the chapters describing the individual benefits.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

CONTACTS

The following chart provides a handy reference guide to telephone numbers you'll see in this SPD.

Administrative Office (for questions about your benefits or requests for Contract Provider directories)	(775) 826-7200 Toll Free 1-877-826-5053
Nevada Health Care Professional Review Organization (Utilization Review representative for urgent care claims for medical treatment)	(775) 826-7200 Fax: (775) 826-7289
Addiction Recovery Program (for referrals for chemical dependency treatment)	1-800-562-3277
RxAmerica (for retail pharmacy network and administration)	1-800-770-8014
American Diversified Pharmacies (ADP) (for mail order prescription drugs)	1-877-889-3402
Operating Engineers Local 3	(775) 857-4440 1-800-922-6100

Chapter 2

PARTICIPATING IN THE BENEFIT PLAN

In this chapter you'll find:

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

EMPLOYEE ELIGIBILITY

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

- **Employees of contributing employers**—You may participate in the benefit plans if you are covered by a collective bargaining agreement or subscription agreement negotiated by Operating Engineers Local Union No. 3 of the International Union of Operating Engineers that requires your employer to make contributions to the health and welfare Trust Fund on your behalf. Participation is also allowed for non-collectively bargained employees of contributing employers when the employers enroll such employees and make flat rate contributions for them each month.
- **Owner-Operators**—If you are an Owner-Operator (not eligible as a result of employment with a contributing employer), you may elect to participate in the Plan by making the required monthly flat rate contribution to the Trust Fund on your own behalf. To be eligible, you must be signatory to an approved Owner-Operator Agreement requiring such contributions and be a dues-paying member or pay a service fee to Operating Engineers Local No. 3.

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

Establishing and Maintaining Your Eligibility

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

If You Have Coverage Elsewhere

If you or your dependents have health care coverage elsewhere, you should be aware that benefits described in this booklet will be coordinated with the other coverage. You cannot receive duplicate benefit payments or use dual coverage to get reimbursed for more than 100% of your expenses. See "Coordination of Benefits" in chapter 13 for more information.

ENROLLMENT

Enrollment Cards

You must complete an enrollment card to

- designate your dependents for dependent coverage and
- designate your beneficiary or beneficiaries for your life insurance, accidental death and dismemberment insurance, and burial expense benefits.

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

If you need an additional enrollment card, you may obtain one from your Local Union Office or the Administrative Office.

Changes

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

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

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

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

Medicare

If you are still an active employee when you reach age 65, you may enroll in Medicare. For Employers with more than 20 employees, this Plan will continue to provide primary coverage for you and Medicare will be secondary. You may elect Medicare as your primary coverage. If you elect Medicare as primary, this Plan will NOT provide secondary coverage. For Employers with less than 20 employees, Medicare will provide primary coverage and the Plan will provide secondary coverage. If your spouse reaches age 65 while you are still an active employee, he or she may enroll in Medicare independently. See chapter 7, "Medicare Reimbursement," for information about receiving reimbursement from the Fund for the premiums required for Part B of Medicare.

COLLECTIVELY BARGAINED EMPLOYEES

Your Hour Bank

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

Banking Excess Hours

Whenever you work more than 110 hours during a month (or have more than 110 hours credited to you under these eligibility rules), the excess hours will be accumulated to provide subsequent eligibility. You can accumulate up to 990 excess hours in your hour bank. (If you have up to the 1,200 excess hours formerly allowed to accumulate, you retain your right to use these hours. Once the balance in your hour bank has fallen below 990 hours, however, 990 excess hours will be the maximum you can accumulate.)

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

If Your Employer Contributes at Less Than the Standard Rate

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

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

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

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

When Coverage Starts

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

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

When Coverage Ends

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

- midnight the last day of the month that your hour bank is exhausted
- the last day of the month prior to which you become eligible for coverage as a retired employee (but see "Retirees Under the Hour Bank System" on page 14)
- the date the Plan terminates.

Re-Establishing Eligibility

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

For example . . . *Let's say you were last eligible for benefits in November 2003 and you next work 110 hours in October 2004. You would be eligible for benefits in November 2004. However, if you were last eligible in November 2003 but did not work 110 hours again until November 2004, you would need to re-establish eligibility by working 330 hours in three consecutive months or less.*

When You Work in More than One Area

Reciprocity

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

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

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

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

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

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

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

If You Change to a Flat Rate Job

If you accumulate an hour bank and then change to a job status where flat rate contributions are made to the Trust Fund for you, you will keep your hour bank. Deductions will resume once you return to employment under the hour bank system or if flat rate contributions cease.

MONTHLY FLAT RATE AND NON-COLLECTIVELY BARGAINED EMPLOYEES

Monthly Rates

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

Classes of Employees

Non-Collectively Bargained Employees

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

Owner-Operators

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

When Coverage Starts

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

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

Pre-Existing Conditions

There is a limit of $2,000 per calendar year for pre-existing medical conditions of a non-bargaining unit office employee, company officer or Owner-Operator. This limit also applies to each dependent of a non-bargaining unit office employee, company officer or Owner-Operator.

A "Pre-existing Condition" means a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six months prior to the individual's enrollment date. The $2,000 limit does not apply to pregnancy-related expenses, or to newborns or children who are adopted or enrolled within 30 days of the birth or adoption.

The limit applies only for the first twelve months, reduced by the period of creditable coverage the person has as of his enrollment date. If you do not enroll as soon as you are eligible, you will be considered a "late enrollee." The limit will apply for the first eighteen months, reduced by the period of creditable coverage the person has as of the effective date of coverage.

Maintaining Eligibility

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

Termination of Eligibility for Employees

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

- the last day of the month for which the required monthly contribution is made on your behalf
- the last day of the month prior to the month you become eligible for coverage as a retired employee
- the date the Plan terminates

Re-Establishing Eligibility

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

COVERAGE DURING FAMILY/MEDICAL AND MILITARY LEAVES

Coverage During an FMLA Leave of Absence

The Fund assists Contributing Employers in complying with the Family and Medical Leave Act (FMLA) by extending benefits during a qualified leave of absence, up to twelve weeks in a year. During your qualified FMLA leave, you and your eligible dependents continue to be covered under this Plan provided you were eligible when the leave began. Your employer determines whether or not your leave is qualified. Your employer must also report the hours (or months for non-collectively bargained employees) and remit the applicable contributions for your coverage to be continued during your leave.

Coverage During Service in the Uniformed Services

If you are an active employee whose employment is interrupted because of a furlough or leave of absence for military service in the Uniformed Services of the United States, Federal law provides certain rights to continued coverage under this Plan. You may choose to freeze your eligibility status or continue coverage for up to 24 months from the date service commences (See Termination of COBRA Continuation Coverage on page 68).

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

Freezing of Your Eligibility

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

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

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

Continuation of Coverage

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

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

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

- 24 months beginning on the day that the uniformed service leave commences or
- a period ending on the day after you fail to return to employment within the time allowed by USERRA.

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

Service-Connected Illnesses and Injuries

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

RETIREES UNDER THE HOUR BANK SYSTEM

You may continue your health coverage by self-payment as described in "COBRA Continuation of Health Care Coverage" in chapter 13.

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

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

DEPENDENT ELIGIBILITY

Eligible dependents can be covered for health care benefits (medical, prescription drug, dental, vision care) and dependent life insurance. In addition, your spouse can receive the Medicare Part B premium reimbursements.

Your eligible dependents are:

- Your lawful spouse
- Your unmarried children who are not in full-time service in the Uniformed Services, if they are:
  - Natural children younger than 19 years of age; or
  - Legally adopted children younger than 19 years of age, from the date of custody; or
  - Stepchildren or foster children younger than 19 years of age provided that:
    - they reside in your household for more than one-half of the year;
    - you claim the child as a dependent for income tax purposes (they may not earn more than the IRS exemption amount), and
    - you have the legal responsibility for payment of all medical and dental expenses for the children.
  - Children under the age of 19 who are required to be covered by the Eligible Employee by a Qualified Medical Child Support Order (QMCSO). For more information on QMCSOs, see chapter 13.

Extended Eligibility for Full-Time Students

A dependent child who is a full-time student or enrolled for nine or more semester units at an accredited educational institution can be covered through age 23.

Extended Eligibility for Disabled Children

You may continue coverage for dependent children beyond age 19 if they are prevented from earning a living because of a mental or physical disability. For them to continue receiving coverage, they must have been eligible dependents and already suffering from this disability when they reached age 19 and they must remain disabled, unmarried, and wholly dependent on you for support. You will need to file evidence of the child's dependence and incapacity with the Board within 31 days after the child reaches age 19 and periodically thereafter upon request.

Termination of Eligibility for Dependents

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

NOTE: No coverage is provided for a dependent while he or she is in full-time service in the Uniformed Services.

EXTENSIONS DURING TOTAL DISABILITY

Extended Medical Benefits for Total Disability

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

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

This extension applies only to the disabled person and not to other family members. It covers charges only for that disability. It is available at the time of termination of eligibility but not after COBRA coverage has been exhausted.

Extended Life Insurance Coverage

Extended Coverage for You If You Become Disabled

Your employee life insurance will stay in effect beyond the end of your eligibility as an active employee if you become totally disabled and unable to work while you are insured under the Plan and before you have reached age 60. For purposes of this extended benefit, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience. See chapter 9, "Employee Life Insurance," for more information.

Extended Coverage for Your Dependents If You Die

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

AFTER ELIGIBILITY TERMINATES

Handling of Your Health Care Coverage

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

COBRA

Legislation known as COBRA gives you and/or your dependents the option of continuing coverage at your own expense under certain circumstances when coverage would otherwise end. See "COBRA Continuation of Health Care Coverage" in chapter 13 for more information.

Certificate of Creditable Coverage

If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan may be used to reduce the length of any pre-existing condition exclusion period contained in your new plan.

When your coverage ends under this Plan, you will receive a certificate of creditable coverage. This certificate provides information your new plan may need. You should check with your new plan's administrator to verify whether your new plan has a limitation for pre-existing conditions and how creditable coverage is applied under that plan. Present your certificate to your new plan so that your new plan will know to apply your creditable coverage to the pre-existing condition exclusion period under your new plan.

The certificate will be sent to you automatically when your coverage terminates and at the end of your COBRA continuation coverage. You may also make a written request for a certificate within two years of when your Plan coverage terminated.

Conversion of Life Insurance

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

Separate Plan for Pensioners

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

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

Chapter 3

COMPREHENSIVE MAJOR MEDICAL BENEFITS

In this chapter you'll find:

- A quick-reference guide to medical benefits
- How the Plan works
- Your share of expenses – deductible and coinsurance
- Lifetime maximum benefit
- Pre-existing condition provision
- Required procedures for hospitalization and chemical dependency treatment
- Covered services and supplies
- Exclusions from coverage
- Information on filing claims

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

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

Comprehensive Major Medical Benefits		
General Plan Features		
Maximum lifetime benefit	$1,000,000 per individual	
Calendar-year deductible	$200 per person, limited to $600 per family	
What the Plan Pays	**Contract Provider:**	**Non-Contract Provider:**
Second Surgical Opinion	80% of the contract rate.	80% of the Scheduled Allowance.
Outpatient Mental Health Care for Employees only (no benefits are provided for dependents)	50% of the contract rate.	30% of the Scheduled Allowance.
Attention Deficit Disorder & Attention Deficit Hyperactivity Disorder (ADD & ADHD).	50% of the contract rate.	30% of the Scheduled Allowance.
Treatment of Chemical Dependency	See page 29	Not covered
Diet and Lifestyle Modification Program (Employee and spouse only)	See page 21	Not covered
All other Covered Expenses	90% of the contract rate.	60% to 90% of the Scheduled Allowance.

Maximum you pay each year for Covered Expenses	The Fund will pay the applicable percentage of Covered Expenses shown above. After you have paid $5,000 in out-of-pocket expenses for Contract Providers and $10,000 for Non-Contract Providers, the Fund pays 100% of Covered Expenses for the rest of the calendar year. If you obtain services from both a Contract and Non-Contract Provider, the out-of-pocket maximum per person is $10,000.

Pre-existing condition provision (Non bargaining participants only)	Benefits for pre-existing conditions initially limited to $2,000 per calendar year if you are under the flat rate contributions system.

HOW THE PLAN WORKS

Contract Providers

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

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

For example . . . *Let's say you are scheduled for outpatient surgery. The contracted rate for the surgical procedure is $800, and the scheduled allowance is $500. If you use a Contract Provider, you pay only 20% of $800, or $160, assuming you previously satisfied the deductible. If you use a Non-Contract Provider, you pay 40% of the $500, or $200, plus 100% of any amount that doctor charges in excess of the $500 scheduled allowance. If the Non-Contract Provider charged $1,000, your share of the costs would be $200 plus the $500 excess, or $700, assuming that you previously satisfied the deductible.*

Non-Contract providers are under no obligation to limit their charges to the scheduled allowances.

Provider Check

The Contract Provider directory is updated periodically and is provided to you without charge. If you are not sure you have the most recent copy, contact the Administrative Office. We also recommend that you confirm that your health care provider is currently contracted.

Call the Administrative Office at (775) 826-7200 to confirm that your provider is contracted so that you can receive the best available benefits.

Chemical dependency treatment requires you to use specific providers if you want to receive benefits. See "Required Referrals for Chemical Dependency" later in this chapter.

The Diet and Lifestyle Modification Program requires you to use specific providers if you want to receive benefits.

COVERED EXPENSES: CONTRACT RATES AND SCHEDULED ALLOWANCES

The Fund contracts with Hospitals, Physicians, Allied Health Care Practitioners and other health care providers. These providers have agreed to contract rates. The Plan bases its payment on the contract rates.

Other providers have not agreed to contract rates. The Plan bases its payment on scheduled allowances. For services where Current Procedural Terminology (CPT) applies, payment to Non-Contract Providers will be based on CPT guidelines. For most professional services, the scheduled allowances are based on the *1974 Relative Value Studies.* For some services, the allowances may be a stated dollar amount or they may be based on the amount that a Contract Provider would accept.

ANNUAL DEDUCTIBLE

The deductible is the out-of-pocket expense you must pay during any one calendar year before the Fund pays benefits. The individual deductible is $200 of Covered Expense incurred in a calendar year, limited to a maximum of $600 per family during a calendar year. Non-Covered Expenses, including expenses in excess of the scheduled allowances for a Non-Contract Provider, may not be used to satisfy the deductible. Covered Expenses incurred and applied against the deductible in the last three months of a calendar year may also be applied against the deductible for the next following calendar year. The deductible does not apply towards the out-of-pocket maximum.

PERCENTAGE PAYABLE

The Plan pays a percentage of Covered Expenses. See "What the Plan Pays" on page 17. For Contract Providers, the Plan pays a percentage of the Contract Rate. For Non-Contract Providers, the Plan pays a percentage of the Scheduled Allowance. Some Hospitals may be contracted only for inpatient services or for specific outpatient services. For Hospital outpatient services, the determination of whether the Hospital will be paid as a Contract Provider or a Non-Contract Provider depends on whether the Hospital is contracted for the services you receive.

If an Employee receives medical services while temporarily residing out-of-state to perform work for a Contributing Employer, the Fund will pay the Contract Provider percentage of Reasonable Charges incurred. The Scheduled Allowances for Non-Contract Providers will not apply. Services rendered by an out-of-state Non-Contract Provider, to **out-of-state Residents only**, will be 90% of Non-Contract Provider Scheduled Allowance. If a resident of Nevada seeks services from an out-of-state Non-Contract Provider, the Fund will pay 60% of the Non-Contract Provider Scheduled Allowance.

OUT-OF-POCKET MAXIMUM FOR COVERED EXPENSES

There are limits to the amount of the out-of-pocket expenses for each person (you and each of your dependents). Once the person has paid $5,000 for Contract Providers or $10,000 for Non-contract Providers, the Fund pays 100% of Covered Expenses for that calendar year (unless otherwise noted). If a person obtains services from both Contract and Non-Contract Providers, the out-of-pocket maximum is $10,000.

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

- Charges beyond a scheduled allowance
- Amounts you pay because you receive chemical dependency treatment from providers not covered through the Addiction Recovery Program (see "Required Referrals for Chemical Dependency Treatment" on page 21)
- Amounts you pay because you receive diet and lifestyle modification from a provider other than TrueNorth Health

- Amounts you pay for non-covered services or supplies or non-Covered Expenses

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

LIFETIME MAXIMUM BENEFIT

All comprehensive major medical benefits and prescription drug benefits are limited to a lifetime maximum benefit of $1,000,000 per participant.

Reinstatement Feature for Comprehensive Major Medical Benefits

The amount that remains of your lifetime maximum will be automatically adjusted each January 1: the amount paid for you in benefits the previous years (up to a limit of $10,000) will be added back into your remaining lifetime maximum.

Such reinstatement will be made only to the extent it does not cause your lifetime maximum to exceed the original $1,000,000.

Amounts paid for prescription drugs are not reinstated.

PRE-EXISTING CONDITION PROVISION

If you are under the flat rate contributions (See chapter 2), you are subject to the Plan's pre-existing condition provision.

Benefits for any and all pre-existing medical conditions (or directly related conditions) from which you or your dependent is suffering **are limited to $2,000 per calendar year** for the first 12 months you are covered under this Plan.

A "pre-existing condition" is defined as a condition for which medical advice, diagnosis, care, or treatment was received or recommended during the 6 months immediately prior to your or your dependent's enrollment date for this Plan.

The benefit limit on pre-existing conditions does not apply to pregnancy-related expenses, nor does it apply to any newborn or adopted child who is added to your coverage within 30 days of the birth or adoption.

Reducing the Period of Limited Benefits

You can reduce or eliminate the time during which benefits for a pre-existing condition are limited by demonstrating prior creditable coverage. Your prior, certified coverage will count toward the benefit-limit period for the pre-existing condition if any break in coverage between the old coverage and this Plan lasted less than 63 days.

For example . . . *If you were covered under a prior plan for nine months and there were less than 63 days between the date your prior coverage ended and your Trust Fund eligibility began, the Trust Fund will apply the pre-existing condition limit for only 3 months. If you had at least 12 months of creditable coverage under the prior plan, the Trust Fund will not apply any pre-existing condition limit.*

You will need to present a copy of a Certificate of Coverage from your old coverage (you have the right to request such a certificate). You may obtain that Certificate from your old plan.

HOSPITAL REVIEW BEFORE ADMISSION

Whenever your Physician recommends an elective non-emergency hospital stay, Utilization Review from the Professional Review Organization (PRO) is required. See the QUICK PHONE REFERENCE for contact information. Preauthorization tells you in advance about Plan coverage for an inpatient Hospital

stay. You are responsible for obtaining preauthorization, although your Hospital or Physician may obtain it on your behalf.

The PRO will determine the medical necessity of such Hospital confinement, and if Medically Necessary, the number of authorized days, if any, for the confinement. No benefits are payable for days that are determined not to be medically necessary.

Utilization review is not required in connection with childbirth for a length of stay of less than 48 hours following a normal vaginal delivery or less than 96 hours following a caesarian section.

REQUIRED REFERRALS FOR CHEMICAL DEPENDENCY TREATMENT

If you want to receive benefits coverage for chemical dependency treatment, you must use providers covered through the Operating Engineers Addiction Recovery Program (ARP).

Benefits for required treatment of alcoholism and other chemical dependency are provided only if you or your covered dependent receives treatment under ARP.

Contact the ARP office **before seeking treatment.** The ARP coordinator will assist in making a referral to an appropriate authorized treatment program. All communication with the ARP will be strictly confidential.

You can contact the ARP office at (800) 562-3277.

DIET AND LIFESTYLE MODIFICATION

Call the Administrative Office at (775) 826-7200 for information about this program. You may only use TrueNorth Health for these benefits. No benefits are payable for programs or services by other providers.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

Federal law guarantees certain rights to women:

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

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

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

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

EMERGENCIES

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

An "emergency" is defined as a medical condition that, if not treated immediately, 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, or development of chronic illness, or inordinate physical or psychological suffering.

If you are admitted to a Non-Contract Hospital in an emergency, the Fund will pay 60% of Reasonable Charges incurred for Covered Expenses. If you decline to transfer to a Contract Hospital after it has been determined to be medically safe, benefits for any services after that point will be paid at Non-Contract levels.

URGENT CARE CLAIMS

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

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

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

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

See "Claims Review Procedures" in chapter 13 for more information about urgent care claims, including time frames for response.

Cash Incentive for Recovering Hospital Overcharges

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

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

If you are covered by more than one health plan, you are eligible only if the Northern Nevada Operating Engineers Health and Welfare Trust Fund plan is the primary plan (see "Coordination of Benefits" in chapter 13 for a discussion of which plan is primary).

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

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

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

COVERED SERVICES AND SUPPLIES

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

All benefit payments are subject to the Plan's maximum lifetime benefit. Also, unless noted otherwise, any limits on days, visits, or specific services mentioned below are for all of your Injuries or Illnesses combined.

Hospital Services and Supplies

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

Inpatient Hospital Charges

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

Benefits for hospital stays are paid as shown in the following chart.

Contract Hospital	80% of the contract rate
Non-Contract Hospital	60% of the scheduled allowance
Non-Contract Hospital if you live in the preferred provider service area but require specialized services not available at a Contract Hospital	60% of reasonable charges for covered services *(The Plan reserves the right to determine whether adequate care is available at a Contract Hospital)*

Hospital Outpatient Services. Benefits for expense incurred and billed by the Hospital for the following:

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

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

- Washoe Medical Center is paid as a Contract Hospital for Trauma Center only (including inpatient care) if the condition is determined to be a trauma as defined by NAC450B.770. In all other respects, Washoe Medical Center shall be considered a Non-Contract Provider.
- Northern Nevada Medical Center is paid as a Contract Hospital only for emergency room services and outpatient surgery. It is paid as a Non-Contract Hospital for all other outpatient services.

Skilled Nursing Facility or Other Specialized Facility

Conditions of eligibility for benefits are as follows:

- You or your covered dependent must be transferred directly from a covered hospital inpatient stay of at least 3 days to the skilled nursing facility or other specialized facility.
- You or your covered dependent must be referred to the skilled nursing facility or other specialized facility by a Physician for further care and treatment of the Illness or Injury for which you were hospitalized within 14 days of such confinement.
- Services must be those which are regularly provided and billed by the skilled nursing facility or other specialized facility.
- The services must be consistent with the Illness, Injury, degree of disability, and medical needs of you or your covered dependent, as determined by the professional review organization. Benefits are provided only for the number of days required to treat the Illness or Injury.
- You or your dependent must remain under the active medical supervision of a Physician. The Physician must be treating the Illness or Injury for which you or your dependent is confined in the skilled nursing facility or other specialized facility.

Covered Expenses

- Accommodations in a room of two or more beds, or, if a private room is used, the prevailing charge for two-bed room accommodations in that facility
- Special treatment rooms
- Laboratory exams
- Physical, occupational, and speech therapy

- Oxygen and other gas therapy
- Drugs and medicines approved for general use by the Food and Drug Administration that are used in the facility
- Blood transfusions, blood products, and blood processing

Doctor Visits

Covered Expense

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

Not covered

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

X-Ray and Laboratory Services

Covered Expense

- Outpatient diagnostic radiology and laboratory services

Limitation

- For a Non-Contract Provider performing only the professional component (Modifier 26), the Covered Expense is 40% of the scheduled allowance.

NOTE: For most diagnostic procedures, you can save money by choosing a free-standing facility instead of the outpatient department of a hospital. For most procedures, the outpatient department of a Hospital – even a Contract Hospital – will be considered as a NON-Contract Provider.

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

Second Surgical Opinion

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

Covered Expense

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

Surgery

Covered Expenses

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

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

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

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

Not Covered

- Surgery solely for cosmetic purposes or other services for beautification, except
  - to correct congenital anomalies,
  - to correct functional disorder,
  - as a result of a covered Injury, for services performed within 12 months of such Injury, or
- Transportation of surgeons or family members.
- For dependent daughters, expenses for pregnancy, except for Complications of Pregnancy.
- Eye surgery for refractive error, such as LASIK.

Maternity and Reproductive Services

The Fund pays benefits as noted below for Covered Expenses.

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

Covered Expense

- Obstetrical services, including operations for extrauterine pregnancy, miscarriage on the same basis as other surgery

- Prenatal care on the same basis as other Physician services
- Hospital stay for mother and newborn on the same basis as other hospital stays

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

Not Covered

- A dependent daughter's pregnancy or maternity care, except for Complications of Pregnancy
- Abortion, except where the life of the mother would be endangered if the fetus were carried to term, or except where medical complications have arisen from an abortion
- Services to reverse voluntary surgically induced infertility
- In vitro fertilization, artificial insemination, or any other surgical services to induce pregnancy or related to infertility or any drug therapy or other services to induce pregnancy

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

Preventive Care

The Fund pays benefits as noted below for Covered Expenses.

Covered Expense

- Physical examination **(available only for you and your spouse, not your dependent children)**—The Fund will reimburse you for expenses for a routine physical examination performed by a Physician, including expenses for radiology and laboratory testing, up to a maximum of $300 per eligible person per calendar year
- Annual routine pap smear and pelvic examination*
- Annual routine mammogram for women age 35 and older*
- Colonoscopies once every ten years*
- Well child care
- Routine diagnostic testing or routine childhood vaccinations, in accordance with the "Recommendations for Preventive Pediatric Health Care" published by the American Academy of Pediatrics

* The maximum $300 calendar year physical exam benefit does not apply to routine pap smears and pelvic exams, routine mammograms, or colonoscopies.

Not Covered

- Physical examinations for dependent children except as described as Well Child Benefit
- Routine eye examinations for visual acuity except as described under Vision Benefit
- Any examination required by an employer as a condition of employment

Emergency Services

Covered Expenses

- Physician services—If you or a covered dependent requires the services of a Physician for an emergency medical condition within or outside the state of Nevada, benefits are paid at the same level as hospital benefits for emergency medical conditions.
- Hospital emergency room use and the supplies, ancillary services, drugs, and medicines listed earlier under "Hospital Services and Supplies."

- Hospitalization - If you are admitted to a Non-Contract Hospital in an emergency, the Fund will pay 60% of reasonable charges incurred for Covered Expenses. If you decline to transfer to a Contract Hospital after it has been determined to be medically safe, benefits for any services after that point will be paid at the Non-Contract scheduled allowance.
- Ambulance service—services of a licensed ambulance for the ground transportation of you or your covered dependent to a Hospital. The Reasonable Charges of a licensed air ambulance are also covered if the Board determines that the location and nature of the Illness or Injury made air transportation cost-effective or necessary to avoid the possibility of serious complications or loss of life.

Transplants

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

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

- cornea,
- bone marrow,
- kidney,
- heart,
- heart-lung,
- liver, and
- pancreas.

Covered Expense

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

Treatment of Vertebrae, Spine, Back, or Neck

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

Covered Expense

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

Mental Health

Inpatient mental health treatment is available to you and your dependents as described under Hospital Services and Supplies for up to 30 days per calendar year. For a Non-Contract Hospital, Covered Expenses are limited to $800 per day for a lockdown room or $650 per day for a non-lockdown room.

Benefits for outpatient mental health care are provided to you, the employee, only. No outpatient mental health care benefits are provided to your dependents. The Fund pays for a maximum of 50 outpatient visits per calendar year.

Covered Expenses

- Inpatient psychiatric services when provided by a licensed general hospital
- Outpatient treatment (**for employees only**): psychotherapy and psychological testing provided by a psychiatrist, psychologist, or certified social worker

Not Covered

- Hospital confinements of less than 24 hours for observation or treatment of a mental or nervous disorder
- Inpatient hospital care in excess of 30 days per calendar year.
- Outpatient treatment for dependents

Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder (ADD & ADHD)

Benefits are payable for psychotherapy and psychological testing provided by a psychiatrist, psychologist or certified social worker for the diagnosis of ADD or ADHD up to a maximum of $750 per calendar year.

Chemical Dependency Treatment

Call the Assistance & Recovery Program at (800) 562-3277 for a referral—you must use covered providers to receive benefits.

Covered providers under ARP will include

- ARP-approved treatment facilities and
- ARP-contracted Physicians providing treatment at ARP-approved treatment facilities.
- a Non-ARP Physician providing treatment at an ARP-approved treatment facility

Covered Expense

- Inpatient treatment—Coverage is provided for three confinements per lifetime. Plan benefits are payable according to the following schedule:
  - First confinement: 100% of Covered Expenses, up to a maximum benefit of $6,000
  - Second confinement: 85% of Covered Expenses, up to a maximum benefit of $5,100
  - Third confinement: 75% of Covered Expenses, up to a maximum benefit of $4,500
- Outpatient treatment—Coverage is provided for three courses of treatment per lifetime for rehabilitation, treatment, and counseling received on an outpatient basis. Plan benefits are payable according to the following schedule:
  - First course: 100% of Covered Expenses, up to a maximum benefit of $4,000
  - Second course: 85% of Covered Expenses, up to a maximum benefit of $3,400
  - Third course: 75% of Covered Expenses, up to a maximum benefit of $3,000
- Recovery home/halfway house—Coverage is provided for two stays per lifetime, up to a maximum benefit of $600 per stay
- Diversion/education—Coverage is provided once per lifetime, up to a maximum benefit of $800

Not Covered

- Inpatient or outpatient care in an acute care hospital, including charges made solely for detoxification

Home Health Care and I.V. Therapy

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

Covered Expenses

- Home health care or home I.V. therapy that would have been covered under the Plan if services were performed in a hospital or skilled nursing facility or other specialized facility and that meets the following requirements:
  - Services are prescribed by a Physician to be performed in the your home and are medically necessary.
  - Services are for care and treatment of an Illness or Injury immediately following a period of confinement in a hospital or skilled nursing facility or other specialized facility and are provided in lieu of confinement.
  - Services are performed by or under the supervision of a person or agency that is licensed, certified, or otherwise qualified to perform such services on the same basis as if the services had been performed in a hospital or skilled nursing facility or other specialized facility.
  - Periodic recertification of the necessity for such services and prognosis reports are furnished by the home health care agency and/or the Physician when requested by the Fund.

Not Covered

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

Hearing Aids

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

Covered Expense

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

Durable Medical Equipment (DME), Prostheses, and Orthotics

Covered Expenses

- Rental or purchase of medical equipment and supplies that are ordered by a Physician, are manufactured specifically for medical use, are of no further use when the medical need ends, are usable only by the patient, and are approved as effective and usual and customary treatment of a condition, as determined by the Board
- Oxygen and rental of equipment for its administration
- Fees incurred for maintenance agreements related to the purchase of oxygen concentrators
- Artificial durable devices or equipment that replaces all or part of a bodily organ or that improves the function of an impaired bodily organ (including prostheses following a mastectomy), except dental appliances, which are not covered under medical benefits

- Custom-molded orthotics when provided by a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or podiatrist (D.P.M.) or by a Durable Medical Equipment licensed provider when ordered by a M.D., D.O. or D.P.M. for treatment of the feet

Not Covered

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

Acupuncture

Covered Expenses

- Medically necessary treatment by a licensed acupuncturist for up to 15 visits per calendar year

Smoking Cessation Program

Benefits are limited to a lifetime maximum benefit of $100.

Covered Expenses

- Participation in a smoking cessation program
- Prescription drugs for smoking cessation
- Over-the-counter smoking cessation treatments

Diet and Lifestyle Modification Program – Employee and Spouse only

Call the Administrative Office at (775) 826-7200 for information about this program. You may only use TrueNorth Health for these benefits.

This is a medically supervised inpatient program lasting approximately three weeks that consists of intensive instruction in diet and lifestyle modification and, when appropriate, includes a period of medically supervised fasting. Your Physician must recommend you or your spouse to this program because you meet one of the following criteria:

- A history of non-medicated fasting blood sugar of 126 mg/dl (7mmol) or greater, or a current diagnosis of Type 1 or Type 2 diabetes mellitus and active use of insulin and/or oral medication for diabetes; or
- A history of repeated non-medicated resting systolic blood pressures equal to or greater than 140 mm/Hg or diastolic blood pressures equal to or greater than 90mm/GH or a current diagnosis of hypertension and active use of antihypertensive medications.

Covered Expense

- Up to three residential treatment programs per lifetime. Plan benefits are payable according to the following schedule:
    - First confinement: 100% of Covered Expenses
    - Second confinement: 85% of Covered Expenses
    - Third confinement: 75% of Covered Expenses

Not Covered

- Care by any provider other than TrueNorth Health

Additional Services and Supplies

Covered Expenses

- Services of a registered nurse or licensed vocational nurse when these services are medically necessary and approved by the Board of Trustees
- Services of a registered physical therapist required for the treatment of an acute medical condition and prescribed by a Physician
- Surgical dressings, splints, casts, and other devices for reduction of fractures or dislocations
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products
- Radiation therapy and chemotherapy
- Trigger point injections for up to five trigger point injections per visit (limited to one visit per day) and a maximum of 15 visits per calendar year
- Temporal Mandibular Joint (TMJ) Syndrome. Regular Plan benefits for treatment of TMJ are payable up to a lifetime maximum of $1,500.

Not Covered

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

EXCLUSIONS FROM COVERAGE

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

- Any expenses that
  - exceed "reasonable" and "customary" charges,
  - are for services and supplies that are not deemed "medically necessary," or
  - are incurred by you or a dependent on a date you are not covered by the Plan (an expense is deemed to have been incurred on the date the person receives the service or supply for which the charge is made).

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

- (*If this Plan is secondary when coordinating benefits with another plan that has entered into a preferred provider agreement with a medical or hospital provider*) Any amount exceeding the difference between the normal charges billed for the expenses by the provider or the contractual rate for such expense under the preferred provider agreement (whichever is less) and the amount that the other plan pays as primary (*This exclusion is in addition to any other limits generally applicable to this Plan or its coordination of benefit provisions*)
- Charges for well baby care, routine physical examinations, outpatient psychotherapy and psychological testing for dependents or chemical dependency treatment, except as specifically provided in the Plan or discussed earlier in this chapter
- Outpatient prescription drugs (*see chapter 4,"Prescription Drug Benefits," for information on coverage of prescription drugs*)
- Custodial care or rest cures; services provided by a rest home, a home for the aged, a nursing home, or any similar facility; or custodial hospital care
- Dental plates, bridges, crowns, caps, or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except treatment for tumors or cysts or treatment necessary to repair or alleviate damage to natural teeth as a result of an accident (*see chapter 5, "Dental Benefits", for information on coverage of such benefits)*
- Eye refractions or eyeglasses or eyeglass fitting (*see chapter 6, "Vision Benefits," for information on coverage of such benefits*)
- Any surgical procedure to correct nearsightedness or farsightedness
- Expenses for transportation of physicians or family members
- Any services or supplies excluded under "General Exclusions, Limits, and Reductions" in chapter 13
- Injuries an individual inflicts on himself, attempted suicide, or drug abuse, except as discussed in chapter 3 under "Mental Health" and Chemical Dependency Treatment" in "Covered Services and Supplies"

HOW TO FILE A CLAIM FOR MEDICAL BENEFITS

NOTE: The discussion below applies to "post-service claims"—claims you submit after you have received a service. The following are also considered claims: requests for expedited approval in cases meriting treatment as urgent care claims and decisions regarding treatment in progress. See "Urgent Care Claims" earlier in this chapter and "Claims Review Procedures" in chapter 13 for more information.

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

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

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, forms supplied by hospitals and physicians are usually acceptable substitutes for claim processing.*)
- Complete your portion of the form, including information about other coverage
- Have the person providing services complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
    - Your (the employee's) name and Social Security number
    - The patient's name and date of birth and relationship to you
    - The date of service

- The CPT-4 codes—the codes for physician services and other health care services found in the *Current Procedural Terminology, Fourth Edition*, as maintained and distributed by the American Medical Association
- The ICD-9 codes—the diagnosis codes found in the *International Classification of Diseases, 9th Edition, Clinical Modification* as maintained and distributed by the U.S. Department of Health and Human Services
- The billed charge(s)
- The number of units (for anesthesia and certain other claims)
- The Federal taxpayer identification number (TIN) of the provider
- The billing name and address
- If medical services were rendered because of an accident, the date and place of the injury, including details (i.e., automobile accident, fall, etc.)

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

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

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

If You Have Other Insurance

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

The claim form (which members are required to complete, sign, and submit to the Administrative Office at least once each calendar year) asks you whether you have other insurance. By entering the requested information on the form, you take care of your notification responsibility.

Chapter 4

PRESCRIPTION DRUG BENEFITS

In this chapter you'll find:

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

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

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

Prescription Drug Benefits	
General Plan Features	
Maximum benefit	$1,000,000 for each person. Payment for prescription drugs are also subject to and accumulate toward the lifetime maximum for the Comprehensive Major Medical Benefits described in Chapter 3.
Calendar-year deductible	None (although the per-prescription copayments are sometimes called "deductibles")
Calendar-year limit on your copayments	None
Pre-existing condition provision	None
Benefits for Covered Prescription Drugs	
If you fill your prescription at a retail pharmacy	You pay a copayment of $10 for up to a 34-day supply of a generic drug $25 for up to a 34-day supply of a brand-name name $20 for up to a 34-day supply of a brand-name drug if no generic is available or your physician specifically requests the brand-name drug Fund covers remaining cost *Certain drugs are covered for a supply limit of up to 100 tablets.*

If you order your prescription through American Diversified Pharmacies (ADP) mail order service	You pay a copayment of $0 for up to a 90-day supply of a generic drug $50 for up to a 90-day supply of a brand-name name $40 for up to a 90-day supply of a brand-name drug if no generic is available or your physician specifically requests the brand-name drug Fund covers remaining cost.

HOW THE PLAN WORKS

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

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

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

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

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

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

Contract Provider Directory

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

MAXIMUM BENEFIT

Your prescription drug benefits are limited to a $1,000,000 lifetime maximum benefit.

NOTE: Benefits the Fund pays for prescription drugs also count toward the maximum lifetime benefit of $1 million that applies to your comprehensive medical benefits. The copayments you make for prescription drugs do not count toward the calendar-year limit on your out-of-pocket coinsurance payments for medical benefits.

BENEFITS AT RETAIL PHARMACIES

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

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

Exceptions to Supply Limit

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

- nitroglycerine
- oral anti-diabetic drugs
- phenobarbital
- thyroid U.S.P.

MAIL ORDER SERVICE

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

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

First-time Prescriptions

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

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

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

Refills

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

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

COVERED DRUGS AND SUPPLIES

Covered expenses include charges for the following:

- Drugs prescribed by a physician or dentist and dispensed by a licensed pharmacist
- Insulin and insulin injection kits purchased from a licensed pharmacist

- Drugs or insulin or insulin injection kits that are supplied to you or a covered dependent in the physician's or dentist's office and are charged separately from any other item of expense
- Drugs or insulin or insulin injection kits supplied by a hospital that are for use outside the hospital in connection with treatment received in the hospital, provided they are prescribed by your physician or dentist
- Compounded dermatological preparations prescribed by a physician and dispensed by a licensed pharmacist
- Therapeutic vitamins, cough mixtures, antacids, and eye and ear medications prescribed by a physician for the treatment of a specified Illness and dispensed by a licensed pharmacist
- Vitamins that require a prescription
- Oral and injectable contraceptives and devices that require a physician's written prescription or a physician office visit (these are covered only for employees and spouses, not for dependent children)
- New drugs approved by the Federal Food and Drug Administration

EXCLUSIONS FROM COVERAGE

No prescription drug benefits are provided for the following:

- Drugs you or a dependent takes or is administered while in the hospital
- Patent or proprietary medicines not requiring a prescription (except insulin)
- Appliances, devices, bandages, heat lamps, braces, or splints
- Vitamins that do not require a prescription, cosmetics, dietary supplements, or health and beauty aids
- Any filling or refilling of a prescription for drugs in excess of the supply limits mentioned above
- Any services or supplies excluded under "General Exclusions, Limits, and Reductions" in chapter 13

HOW TO FILE A CLAIM FOR PRESCRIPTION DRUG BENEFITS

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

- Obtain a claim form from the Union or the Administrative Office.
- Complete your portion of the form.
- Have the pharmacy complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
    - Your (the employee's) name and Social Security number
    - Name and address of the individual for whom the drug was prescribed
    - Birth date of the individual for whom the drug was prescribed and that individual's relationship to you
    - Name, address, and tax ID number of the dispensing pharmacy
    - Date each prescription was dispensed and cost of each prescription
    - The billing name and address

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

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

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

Chapter 5

DENTAL BENEFITS

In this chapter you'll find:

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

Your dental benefits provide coverage for services ranging from checkups and cleanings to dentures. The Plan also provides benefits for orthodontic care for eligible dependent children under age 19.

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

Dental Benefits		
General Plan Features		
Maximum calendar year benefit	$2,500 per individual	
Maximum lifetime benefit for orthodontia	$2,500 per individual Orthodontic benefits are available only to your dependent children under age 19	
Calendar year deductible	None	
Benefits for Covered Services and Supplies		
	Contract Providers	**Non-Contract Providers**
Diagnostic care: • **Oral examination** • **Bite-wing X-rays (once every 6 months)** • **Full-mouth X-rays (once every 3 years)** • **Emergency palliative treatment** • **Specialist consultation**	90% of the contract rates	80% of the applicable amount shown in the Schedule of Dental Allowances
Preventive care: • **Cleanings (once in any 6-month period)** • **Fluoride treatment (once in any 6-month period)** • **Application of sealants for dependent children 14 years of age and under (molar teeth only)**	90% of the contract rates	80% of the applicable amount shown in the Schedule of Dental Allowances

Basic Services and Restorations • **X-rays (other than bitewing X-rays), study models, space maintainers** • **Oral surgery** • **Fillings** • **Endodontics—treatment of the tooth pulp, including necessary X-rays and cultures** • **Periodontics—treatment of gums and bones supporting teeth** • **Crowns, jackets, and cast restorations (replacement is covered only once every 5 years)**	90% of the contract rates	80% of the applicable amount shown in the Schedule of Dental Allowances
Fixed Bridges, Partial and Complete Dentures • **Construction or repair of fixed bridges or partial or complete dentures** • **Relines and rebases**	60% of the contract rates	60% of the applicable amount shown in the Schedule of Dental Allowances
Orthodontic Services		
All-inclusive orthodontic care	Fund pays 100%, up to maximum lifetime benefit of $2,500	

HOW THE PLAN WORKS

Your dental benefits have been structured to provide an incentive for you to use a Contract Provider—a dentist that has contracted with the Fund to provide services at a negotiated rate. Benefit payments are based on the contract rates.

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

MAXIMUM BENEFITS

The Fund pays up to $2,500 in dental benefits per individual per calendar year.

Orthodontic care has a separate lifetime maximum benefit of $2,500 per individual. Orthodontic benefits are available only for your dependent children under age 19 or under age 24 if a full time student.

COVERED SERVICES

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

To be covered, services must be necessary and customary, as determined by the standard of generally accepted dental practice. Expenses are deemed to be incurred on the date the service or supply is rendered.

Diagnostic and Preventive Services

- Diagnostic care—procedures to assist the dentist in evaluating existing conditions to determine the required dental treatment, including the following:
    - Oral examination
    - Bitewing X-rays (once every six months)
    - Full mouth X-rays (once every three years)
    - Emergency palliative treatment
    - Specialist consultation
- Preventive care:
    - Cleanings (one treatment in any 6-month period)
    - Fluoride treatment (one treatment in any 6-month period) for dependent children 14 years of age and under
    - Application of sealants for dependent children 14 years of age and under (covered for molar teeth only)

Basic Services and Restorations

- X-rays (other than bitewing X-rays), study models, space maintainers
- Restorative—amalgam, synthetic porcelain, and plastic restorations (fillings) for treatment of carious lesions (The allowance for amalgam restorations will be substituted for composite restorations posterior to the second bicuspid)
- Endodontics—treatment of the tooth pulp, including necessary X-rays and cultures
- Periodontics—treatment of gums and bones supporting teeth
- Oral surgery—extractions and certain other surgical procedures, including pre- and post-operative care.
- Crowns, jackets, and cast restorations (replacement is covered only once every five years)

Fixed Bridges, Partial or Complete Dentures

- Procedures for construction or repair of fixed bridges or partial or complete dentures
- Relines and rebases, including all lab or chairside treatment

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

Orthodontic Services

The Fund provides all-inclusive orthodontic care benefits for eligible dependent children under age 19 and dependent children under age 24 if a full time student. The Fund pays 100% of expenses (other than those specifically excluded immediately below), up to the lifetime maximum benefit of $2,500 per individual.

Orthodontic care benefits will not be paid for the following:

- Treatment plans that are unlikely to produce professionally acceptable corrections of existing malocclusion, such as (but not limited to) those for individuals with severe periodontal problems, poor bone structure, or extremely short roots

- Orthodontic treatment that will require major restorative dental work not ordinarily performed in general dentistry
- Replacement of lost or broken appliances or retainers

EXCLUSIONS FROM COVERAGE

Dental benefits will not be paid for the following:

- The replacement of a lost, misplaced, or stolen appliance before the normal prosthodontic period has passed
- Dental treatment involving the use of more costly materials (for example, gold) if such treatment could have been rendered at a lower cost by means of a reasonable substitute
- Expense incurred as a result of broken appointments
- Dietary planning, oral hygiene instruction, or training in preventive dental care
- Services in connection with preparation of a prosthetic appliance, including a crown or bridge, or any other dental expense incurred before you and your dependents became eligible for coverage, including diagnostic work prior to treatment
- Prosthodontic services or any single procedure started before you and your dependents became eligible for such services under this Plan, for example, teeth extracted prior to the date you were eligible for coverage, unless the denture or fixed bridgework also includes replacement of a natural tooth that is extracted while you are covered and the appliance is not an abutment to a partial denture or fixed bridgework installed within the preceding 4 years
- Prosthodontic appliances, crowns, or bridges that were ordered while you or a covered dependent were eligible but are not installed or delivered until more than 60 days after termination of eligibility
- Any bodily injury or illness for which you or a covered dependent is not under the care of a dentist
- Expenses in connection with occupational injuries or illnesses
- Services performed by the spouse, child, brother, sister, or parent of the patient
- Any services or procedures that are experimental in nature or are not within the standards of generally accepted dental practice
- Services for congenital (hereditary) or developmental (following birth) malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth)
- Services for restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to the teeth's being out of alignment or occlusion, or for stabilizing the teeth and related procedures, including but not limited to equilibration and periodontal splinting
- Prescribed drugs, premedication, or analgesia when not included in the charge for covered dental services
- All hospital costs and any additional fees charged by the dentist for hospital treatment
- Charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgery services
- Implants (materials implanted into or on bone or soft tissue) or the removal of implants
- Any services or treatments excluded under "Covered Services" above
- Any services or treatments excluded under "General Exclusions, Limits, and Reductions" in chapter 13

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

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

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

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, your dentist may use a standard claim form.*)
- Complete your portion of the form.
- Have the dentist's office complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
    - Your (the employee's) name and Social Security number
    - Patient's name and address
    - Patient's birth date and relationship to you
    - Name, address, and tax ID number of the dentist providing services
    - The codes for the dental procedures performed
    - Date each service was performed and cost for each service
    - The billing name and address
- Mail your claim form with your itemized bills to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.
- Mail any further bills or statements for any services covered by the Plan to the Northern Nevada Operating Engineers Health and Welfare Trust Fund as soon as you receive them.

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

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

Chapter 6

VISION CARE BENEFITS

In this chapter you'll find:

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

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

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

Vision Care Benefits

All benefits shown are available once per calendar year.

General Plan Features	
Maximum benefit	No lifetime or overall calendar-year maximum
Calendar-year deductible	None

Reimbursement Allowances for Covered Services and Materials			
Item	**Contract Provider**	**Reimbursement Allowance for Non-Contract Provider**	**Reimbursement Allowance for Non-Contract Provider in Humboldt, Pershing, White Pine, Elko, Eureka, or Lander County**
Exam	100% of the contract rate	up to $40	up to $50
Frames	100% of the contract rate on select frames	up to $35	up to $43.75
Eyeglass lenses:		*(All reimbursements are per pair)*	*(All reimbursements are per pair)*
• **Single vision**	100% of the contract rate	up to $36	up to $45
• **Bifocal**	100% of the contract rate	up to $55	up to $68.75
• **Trifocal**	100% of the contract rate	up to $70	up to $87.50
• **Lenticular**	100% of the contract rate	up to $150	up to $187.50

Tints and coatings:			
• **Photogrey tint or UV coating (employee only)**	up to $20	up to $20	up to $25
• **Tint, Rose #1 or #2 (dependents)**	up to $7	up to $7	up to $8.75
Contact lenses (instead of glasses):			
• **Medically necessary**	up to $225 per pair	up to $225 per pair	up to $281.25 per pair
• **For cosmetic purposes**	up to $96 per pair	up to $96 per pair	up to $120 per pair

HOW THE PLAN WORKS

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

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

COVERED SERVICES AND MATERIALS

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

Contact lenses may be provided instead of glasses.

Contact lenses are considered medically necessary under the following conditions:

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

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

EXCLUSIONS FROM COVERAGE

The Fund will not pay benefits for the following:

- Replacement of lenses and frames that are lost or broken (except at the normal intervals when services are otherwise available)
- Orthoptic or vision training, non-prescription lenses, glasses secured when replacement is not deemed medically necessary, or a second pair of glasses in lieu of bifocals

- Non-prescription sunglasses
- Medical or surgical treatment of the eyes
- Services or materials provided as a result of any Workers' Compensation law or similar legislation or services that can be obtained without cost from any Federal, state, county, or local organization or agency
- Any eye examination or glasses required by an employer or any service or materials provided by any other vision care plan or group benefit plan containing benefits for vision care
- Any services or treatments excluded under "General Exclusions, Limits, and Reductions" in chapter 13

HOW TO FILE A CLAIM FOR VISION CARE BENEFITS

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

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

- Obtain a claim form from the Union or the Administrative Office. (*If it is not possible for you to get a Plan claim form, forms supplied by vision care providers are usually acceptable substitutes for claim processing.*)
- Complete your portion of the form.
- Have the vision care provider complete the rest of the form.
- Check the claim form to be certain that all applicable portions of the form are completed. Be sure your bills are itemized. The following information should be indicated on the bills or claim form submitted:
    - Your (the employee's) name and Social Security number
    - Patient's name and address
    - Patient's birth date and relationship to you
    - Name, address, and tax ID number of the optometrist, ophthalmologist, or optician providing services
    - Date each service was performed and cost for each service
    - The billing name and address
- Mail your claim form with your itemized bills to the Northern Nevada Operating Engineers Health and Welfare Trust Fund, P.O. Box 11337, Reno, Nevada 89510.
- Mail any further bills or statements for any services covered by the Plan to the Northern Nevada Operating Engineers Health and Welfare Trust Fund as soon as you receive them.

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

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

Chapter 7

MEDICARE PREMIUM REIMBURSEMENT

In this chapter you'll find:

- How the Plan works
- When reimbursements are made
- Information on filing claims

Medicare Part B Premium Reimbursement	Reimburses you for 100% of the Medicare Part B premium charge.

HOW THE PLAN WORKS

If you are still an active employee and you are eligible for Medicare, the Fund will continue to provide your primary coverage. There are some exceptions to this general rule, as determined by Medicare. Medicare will usually be secondary and will help to pay expenses that are not paid by this Plan. Medicare will also provide primary coverage if your active eligibility terminates.

You may choose Medicare as your primary coverage. If you do, the Fund will NOT provide secondary benefits.

In order to avoid loss of protection, you (or your dependent) should enroll for Parts A and B of the federal Medicare program during the three months before you (or your dependent) will become eligible for Medicare. This should be done at the nearest Social Security Office.

PREMIUM REIMBURSEMENT PAYMENTS

The Fund will reimburse you for your monthly Medicare Part B premiums. Reimbursement payments are made quarterly (in April, July, October, and January). Your reimbursement will include payment for each month during the preceding quarter you and/or your spouse were enrolled in Medicare Part B.

To be eligible for premium reimbursement, you must have been eligible for Fund benefits for at least one month during the 12 months preceding the reimbursement. Premium reimbursement is available to:

- An Employee
- The spouse of an Employee. Even if you are not eligible for Medicare, your Medicare-eligible spouse can receive reimbursements.
- The surviving spouse of a deceased Employee.

A Medicare Reimbursement Application must be filed for the Employee and for the spouse. Retroactive payments will be made ONLY to the beginning of the quarter in which the application was received.

HOW TO FILE A CLAIM FOR REIMBURSEMENT

Obtain a Medicare Reimbursement Application from the Administrative Office.

Complete the application and return it to the Administrative Office each quarter.

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

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

Chapter 8

WEEKLY DISABILITY BENEFITS

In this chapter you'll find:

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

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

HOW THE PLAN WORKS

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

Definition of "Totally Disabled"

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

A physician's certification of total disability is required.

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

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

INJURIES COVERED BY WORKERS' COMPENSATION

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

REPEATED INSTANCES OF DISABILITY

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

- due to unrelated causes or

- separated by a return to active full-time employment for at least two consecutive weeks.

EXCLUSIONS FROM COVERAGE

No benefits are payable for the following disabilities:

- A disability that began before you became eligible for benefits under the Fund
- Any bodily illness or injury for which evidence is not furnished to the Fund that you are totally disabled
- Any disability suffered by your spouse or dependent children (weekly disability benefits cover employees only)

No benefits are payable under the following circumstances:

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

HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

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

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

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

If you disagree with the decision made on your claim, you may appeal the decision. See "Claims Review Procedures" in chapter 13 for more information.

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.

For information on what to do if you disagree with the decision made in regard to your claim, see "Claims Review Procedures" in chapter 13, "Other Important Plan Information."

Chapter 9

EMPLOYEE LIFE INSURANCE

In this chapter you'll find

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

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

Employee Life Insurance	$10,000 coverage

HOW THE PLAN WORKS

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

Payment of the Benefit

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

Your Beneficiary

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

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

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

- your spouse,
- your natural and adopted children, in equal shares,
- your parents, in equal shares, or
- your estate, in equal shares.

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

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

EXTENDED COVERAGE FOR DISABILITY

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

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

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

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

CONVERSION OPTION

If You Cease to Be Eligible for Life Insurance

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

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

Conversion Option Under Other Circumstances

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

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

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

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

Applying for Conversion

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

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

Total Disability Extension

To file for an extension, follow these steps:

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

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

Death Claims

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

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

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

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

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

If you or your beneficiary disagrees with the payment decision made in regard to the claim, a review of the decision can be requested. Please alert your beneficiary to the claims review information provided in chapter 13 of this booklet.

Chapter 10

LIFE INSURANCE FOR DEPENDENTS

In this chapter you'll find:

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

Like employee life insurance, life insurance for your eligible dependents is provided through an insurance contract with ING Employee Benefits (ING). A complete copy of your Life Insurance Plan is included at the end of this Summary Plan Description.

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

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

HOW THE PLAN WORKS

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

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

CONVERSION OPTION

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

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

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

Conversion Option Under Other Circumstances

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

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

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

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

Applying for Conversion

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

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

HOW TO FILE A CLAIM FOR DEPENDENT LIFE INSURANCE BENEFITS

You should notify the Administrative Office as soon as possible after your dependent's death.

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

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

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

If you disagree with the payment decision made in regard to the claim, a review of the decision can be requested. See the claims review information provided in chapter 13 of this booklet.

Chapter 11

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

In this chapter you'll find:

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

Like employee and dependent life insurance, employee AD&D insurance is provided through an insurance contract with ING Employee Benefits (ING). AD&D coverage is not provided for dependents. A complete copy of your Life Insurance Plan is included at the end of this Summary Plan Description.

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

HOW THE PLAN WORKS

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

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

If the loss is your death, the $5,000 benefit will be paid to your beneficiary. You will find more information about beneficiaries in Chapter 9, "Employee Life Insurance." This is in addition to the $10,000 employee life insurance benefit.

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

EXCLUSIONS FROM COVERAGE

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

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

  - unless prescribed by a doctor

  - which is illegal

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

HOW TO FILE A CLAIM FOR AD&D BENEFITS

Death Claims

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

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

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

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

If your beneficiary disagrees with the payment decision made in regard to the claim, a review of the decision can be requested. Please alert your beneficiary to the claims review information provided in chapter 13 of this booklet.

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

Dismemberment and Loss of Sight Claims

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

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

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

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

If you disagree with the payment decision made in regard to the claim, a review of the decision can be requested. Refer to the claims review information provided in chapter 13 of this booklet.

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

Chapter 12

EMPLOYEE BURIAL EXPENSE BENEFIT

In this chapter you'll find:

- How the Plan works
- Information on filing claims

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

Burial Expense Benefit	$2,500

HOW THE PLAN WORKS

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

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

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

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

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

HOW TO FILE A CLAIM FOR THE BURIAL EXPENSE BENEFIT

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

If your beneficiary disagrees with the payment decision made in regard to the claim, he or she can request a review of the decision. Please alert your beneficiary to the claims review information provided in chapter 13 of this booklet.

Chapter 13

OTHER IMPORTANT PLAN INFORMATION

This chapter includes:

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

COORDINATION OF BENEFITS

Coordination of Health Care Benefits

The health care benefits provided by the Fund are "coordinated" with any benefits under any other group plan or government plan that covers you or your dependents.

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

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

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

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

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

- **Spouses:** The plan covering the spouse directly, as a nondependent rather than as an employee's dependent, is the primary plan. The plan covering the spouse as a dependent is the secondary plan.

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

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

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

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

Coordination with Prepaid Plans

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

Coordination with Medicaid

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

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

Coordination with Medicare

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

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

Age-Related Eligibility for Medicare

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

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

End-Stage Renal Disease

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

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

- the month in which Medicare ESRD coverage begins or

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

Beginning with the 31st month (or the 34th month, in the case of a transplant patient), Medicare will become the first payer whether or not the individual is still entitled to coverage under this Plan.

Disability Cases

If you or a covered dependent becomes entitled to Medicare as a result of a disability, Medicare will be the secondary payer while you are covered as an active employee.

Third-Party Payments (Subrogation)

If you or a covered dependent is injured or made ill by the act or failure to act of another person (called a "third party"), the Fund will pay benefits only if you agree to repay them if you later recover damages or receive reimbursement from the third party or an insurance company. You must also agree to help the Fund recover those benefits.

Before accepting any benefits from the Fund, you and your covered dependents shall agree in writing to reimburse the Fund for any payments made by the Fund for hospital, medical, or other expenses in connection with, or arising out of, any such injury, illness, disease. or other condition. The Fund shall have an automatic lien upon any recovery against the third party for benefits paid by the Fund as a result of such illness, injury, disease, or other condition.

You can reimburse the Fund with

- proceeds received by way of judgment, arbitration award, settlement, or otherwise from a claim against the third party, his insurance carrier, guarantor, or other indemnitor,
- any payments you receive under "no fault" motorist coverage, or
- proceeds from any other source of third-party recovery.

You are required to

- prosecute a claim for damages diligently,
- give priority to the reimbursement of the Fund in the allocation of the proceeds of any recovery,
- cooperate and assist the Fund in obtaining reimbursement for such payments,
- execute any documents necessary to secure such reimbursement, and
- refrain from any act or omission that might hinder such reimbursement.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOS)

Under the Omnibus Budget Reconciliation Act of 1993, the Plan recognizes Qualified Medical Child Support Orders (QMCSOs) and enrolls dependent children as directed by such an Order. A Medical Child Support Order is any judgment, decree, or order (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law that

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

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

- the name and last known mailing address of the employee and the name and mailing address of each dependent child covered by the Order,

- a description of the type of coverage to be provided by the Plan to each such dependent child,
- the period of coverage to which the Order applies, and
- the name of each plan to which the Order applies.

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

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

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

When a Qualified Medical Child Support Order Is Received

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

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

COBRA CONTINUATION OF HEALTH CARE COVERAGE

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

Qualifying Events

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

1. Reduction of work hours or reduction to less than the minimum required (110) hours in your hour bank (hours previously banked plus hours reported by your Employer)
2. Your divorce

3. Your death
4. The loss of status as a Dependent child

Duration of COBRA Coverage

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

- **18 Months** - You and/or your Dependents can continue coverage for up to 18 months from the date of the Qualifying Event if you would otherwise lose coverage because less than the minimum work hours were reported for a month on your behalf.
- **29 Months** – An 18-month coverage period can be extended to a total of 29 months if you or your Dependent becomes disabled (as determined by the Social Security Administration) before or during the first 60 days of COBRA coverage. See "Extended COBRA Coverage in Cases of Disability."
- **36 Months** - Each of the other above-listed Qualifying Events (Items 2 through 4) entitles your Dependents to 36 months of coverage from the date of the Qualifying Event. (In the case of a child's losing Dependent status, only the affected child is eligible for 36 months of coverage.)

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

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

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

Extended COBRA Coverage If A Second Qualifying Event Occurs

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

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

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

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

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

Cost of Continuation Coverage – Benefits That May Be Continued

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

Paying for COBRA Coverage

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

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

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

How to Obtain COBRA Continuation Coverage

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

Your Duty to Notify Administrative Office

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

- your divorce from your spouse,
- loss of dependent status by a child, or
- the occurrence of a second qualifying event while your dependents are in an 18-month COBRA continuation period (see "Extended COBRA Coverage If a Second Qualifying Event Occurs" above).

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

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

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

How to Notify the Administrative Office

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

- name of the qualified beneficiary,
- the Participant's name and ID number or social security number,
- the event for which you are providing notice and the date of the event (for example, the date of a dependent child's 19th birthday), and
- a copy of the final marital dissolution if the event is a divorce,
- if your child is no longer a full time student, your letter should include the date he or she last attended school.

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

Where to Send Your Notice

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

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

When to Notify the Administrative Office

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

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

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

Who Can Notify the Administrative Office

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

Electing Continuation Coverage

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

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

YOU MUST SIGN AND RETURN THE ELECTION FORM TO THE ADMINISTRATIVE OFFICE NO LATER THAN 60 DAYS AFTER THE DATE OF YOUR LOSS OF ELIGIBILITY OR THE DATE OF THE COBRA NOTICE FROM THE ADMINISTRATIVE OFFICE

(WHICHEVER IS LATER) OR YOU WILL NOT BE ELIGIBLE FOR COBRA CONTINUATION COVERAGE. COBRA rights will be forfeited if you or your Dependents do not file the COBRA election forms within this 60-day period.

You do not have to show that you are insurable to choose COBRA Continuation Coverage. If you do not choose continuation coverage, your health insurance coverage will end. However, your spouse and/or your eligible Dependents may elect continuation coverage, even if you do not.

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

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

- First, if you have a gap in health coverage of 63 days or more, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans (election of COBRA Continuation Coverage may prevent a gap in coverage).
- Second, if you do not purchase continuation coverage for the maximum time available to you, you will lose the guaranteed right to purchase individual health insurance policies with no pre-existing condition exclusions.
- Finally, you have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special enrollment under this provision is allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA Continuation Coverage if you pay for COBRA Continuation Coverage for the maximum time available to you.

Additional COBRA Election Period and Tax Credit In Cases of Eligibility For Benefits Under TAA

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the Trade Adjustment Assistance Act Amendments of 2002 (TAA), you may be eligible for both a new opportunity to elect COBRA and an individual Health Insurance Tax Credit. If you and/or your dependents did not elect COBRA during your election period, but are later certified by the DOL for TAA benefits or receive pensions managed by the Pension Benefit Guaranty Corporation (PBGC), you may be entitled to an additional 60-day COBRA election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA later than six months after your coverage ended under the Plan. Also under TAA, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at (866) 628-4282. TTD/TTY callers may call toll-free at (866) 626-4282. More information about TAA is available at the website www.doleta.gov/tradeact/2002act_index.asp. The Administrative Office may also be able to assist you with your questions.

Adding New Dependents

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

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

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

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

Termination of COBRA Continuation Coverage

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

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

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

- You or your Dependents fail to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments);
- You or your Dependents become covered under any other group medical plan after the date you elect COBRA coverage; however, if the other group health plan will not cover a pre-existing health problem, COBRA Continuation Coverage will not be terminated;
- You or your Dependents become entitled to Medicare Part A or Part B after the date of your COBRA election;
- Your Employer no longer provides group health coverage to any of its Employees; or
- You or your Dependents have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your Dependents are no longer disabled.

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

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

Keeping the Administrative Office Notified

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

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

COBRA CONTINUATION COVERAGE QUICK REFERENCE CHART

Qualifying Event	Qualified Beneficiary	MAXIMUM CONTINUATION PERIOD
1) Insufficient work hours	You, your spouse and Dependent children	18 months after date of Qualifying Event*
2) Termination of your employment (for reasons other than gross misconduct)	You, your spouse and Dependent children	18 months after date of Qualifying Event*
3) Your death	Your spouse and Dependent children	36 months after date of Qualifying Event
4) Your divorce	Your spouse and Dependent children	36 months after date of Qualifying Event
5) Your child's loss of Dependent status under Plan	Affected Dependent if covered under Plan	36 months after date of Qualifying Event

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

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

CLAIMS REVIEW PROCEDURES

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

Types of Claims

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

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

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

  The Plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, will determine whether your claim is an urgent care claim. Alternatively, any claim that a physician with knowledge of your medical condition determines is an urgent care claim within the meaning above, will be treated as an urgent care claim.
- **Concurrent care decisions:** A concurrent care decision is a decision on a treatment in progress that could result in a reduction, termination, or extension of a benefit. In this situation, a decision to reduce

or terminate treatment is made concurrently with the provision of treatment. This category also includes requests by you or your provider to extend approved urgent care treatment.

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

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

- **Disability claims:** A disability claim is a claim for weekly disability benefits or a claim for a determination of disability (for example, for extended life insurance coverage during a period of disability).
- **Other claims:** The category "other claims" includes claims for Medicare reimbursement, employee and dependent life insurance, employee AD&D insurance, and employee burial expense benefits.

What is NOT a "Claim"

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

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim
- A request for an advance determination regarding the Plan's coverage of a non-urgent medical treatment or service recommended by your physician *(Note, however, that getting such an advance determination does not guarantee payment of Plan benefits. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.)*
- A prescription you present to a pharmacy to be filled (*However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures in this section.*)

Filing a Claim

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

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

Delivering an Urgent Care Claim

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

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

Using an Authorized Representative

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

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

When Claims Must Be Filed

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

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

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

You must submit all other claims **within 90 days** of when expenses are incurred or a loss was experienced, unless you cannot reasonably submit the claim within that time frame. Failure to file claims within that time will not invalidate or reduce any claim if it was not reasonably possible to file the claim within that time. However, in such a case, you must submit the claim as soon as is reasonably possible and in no event later than 1 year after the date charges were incurred or the loss was experienced.

Timing of Initial Claims Decisions

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

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

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

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

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

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

  If an extension is needed because the Administrative Office needs additional information from you, the Administrative Office will notify you as soon as possible, but no later than **30 days** after receipt of the

claim, of the specific information necessary to complete the claim. You and/or your doctor will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days have passed or the date you respond to the request (whichever is earlier). The Administrative Office then has **15 days** to make a decision on your post-service claim and notify you of the determination.

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

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

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

- **Medicare Part B Premium Reimbursement claims:** The Administrative Office will ordinarily make a decision on a claim for Medicare premium reimbursement within **90 days** of receipt of the claim. This period may be extended by up to **90 days** if the extension is necessary due to matters beyond the control of the Administrative Office. If an extension is necessary, you will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Administrative Office expects to make a decision.

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

Denied Claims (Adverse Benefit Determinations)

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

- the specific reason(s) for the determination
- reference to the specific Plan provision(s) on which the determination is based
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary
- a description of the appeal procedures and applicable time limits

- if an internal rule, guideline, or protocol was relied upon in deciding your claim, either a copy of the rule or a statement that it is available upon written request at no charge
- if the determination was based on the absence of medical necessity, or the treatment's being experimental or investigational, or other similar exclusion, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge

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

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

Request for Review of an Adverse Benefit Determination

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

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

The Administrative Office may refer your appeal for life insurance or AD&D to the insurance company. You may appeal an adverse benefit determination regarding urgent care by faxing your request to the Utilization Review representative at (775) 826-7289, calling the Administrative Office at (775) 826-7200, or going to the Administrative Office and asking to speak to the Utilization Review representative.

Review Process

The review process works as follows:

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

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

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

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

Notice of Decision on Appeal

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

- **Urgent care claims:** You will be sent a notice of a decision on review within **72 hours** of receipt of the appeal by the Administrative Office.
- **Concurrent care decisions:** You will receive notice of a decision on review within a reasonable time for the type of care decision.

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

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

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

Limitation on When a Lawsuit May Be Started

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

No lawsuit may be started more than 3 years after

- the end of the year in which health care services were provided (for health care benefits),
- the start of the disability (for disability benefits),
- payment of the Part B premium (for Medicare reimbursement), or
- the date of death or other loss (for life and AD&D insurance or employee burial expense benefits).

Maximum Times for Processing of Health Care Claims *(Times are suspended while the Administrative Office is waiting for additional information it has requested of you)*			
	Urgent Care Claims	**Concurrent Care Decisions**	**Post-Service Claims**
Administrative Office makes initial determination (provided all necessary information is submitted)	Within 72 hours of claim's receipt	In time for you to appeal before a reduction or termination Within 24 hours of request for extension of urgent care	Within 30 days of claim's receipt (can be extended for another 15 days)
Administrative Office notifies you claim has been improperly filed	Within 24 hours of claim's receipt	Not applicable	Not applicable
Administrative Office requests additional information	Within 24 hours of claim's receipt	Not applicable	Within 30 days of claim's receipt
You furnish requested information	Within 2 working days of request	Not applicable	Within 45 days of request
Administrative Office makes determination after requesting information	Within 48 hours of receipt of information or expiration of time allowed	Not applicable	Within 15 days of receipt of information or expiration of time allowed
You make request for appeal	Within 180 days of receiving notice of denial	Within a reasonable time for your situation	Within 180 days of receiving notice of denial
Administrative Office/Board makes decision on appeal	Within 72 hours of receiving your request for appeal	Within a reasonable time for type of care decision	At next regular Board meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)

Maximum Times for Processing of Disability and Other Claims *(Times are suspended while the Administrative Office is waiting for additional information it has requested of you)*		
	Disability Claims	**Other Claims**
Administrative Office or insurance company makes initial determination (provided all necessary information is submitted)	Within 45 days of claim's receipt (can be extended for another 30 days and an additional 30 days after that)	Within 90 days of claim's receipt (can be extended for another 90 days)
Administrative Office requests additional information	Within 45 days of claim's receipt	Not applicable
You furnish requested information	Within 45 days of request	Not applicable
Administrative Office makes determination after requesting information	Within 30 days of receipt of information or expiration of time allowed	Not applicable

Maximum Times for Processing of Disability and Other Claims *(Times are suspended while the Administrative Office is waiting for additional information it has requested of you)*		
	Disability Claims	**Other Claims**
You make request for appeal	Within 180 days of receiving notice of denial	Within 60 days of receiving notice of denial
Board or insurance company makes decision on appeal	At next regular Board meeting or, if appeal is received less than 30 days in advance, at subsequent meeting (may be delayed until third such meeting)	Within 60 days of receiving your request for appeal (can be extended another 60 days)

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Northern Nevada Operating Engineers Health and Welfare Trust Fund (the "Plan") is required by law, including the federal Health Insurance Portability and Accountability Act of 1996, known as HIPAA, to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Plan's duties with respect to your PHI,
4. Your right to file a complaint with the Plan and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Plan's privacy practices.

This Notice applies to your health information held by the Northern Nevada Operating Engineers Health and Welfare Trust Fund and outside companies that help administer the Plan.

Your Protected Health Information

Definitions

- Protected Health Information (PHI) Defined

  The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health conditions, the provision of health care to you, or to past, present, or future payment for the provision of health care to you. PHI includes information transmitted, created or maintained by the Plan in oral, written, or electronic form.

- De-Identified PHI

  This Notice does not apply to information that has been de-identified. De-identified information is information that:

  Does not identify you, and

  With respect to which there is no reasonable basis to believe that the information can be used to identify you.

- Your Personal Representative

You may exercise your rights through your Personal Representative. Your Personal Representative will be required to produce evidence of authority to act on your behalf before the Personal Representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be: (1) a completed, signed and approved Appointment of Personal Representative form; (2) a notarized power of attorney for health care purposes; (3) or a court-appointed conservator or guardian. You may obtain the Appointment of Personal Representative form by calling the Fund Office.

The Plan retains discretion to deny access to your PHI to a Personal Representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Plan will recognize certain individuals as Personal Representatives without you having to provide proof of authority as described above. For example, the Plan will automatically consider a spouse to be the Personal Representative of an individual covered by the Plan. In addition, the Fund will consider a parent or guardian as the Personal Representative of an unemancipated minor unless applicable law requires otherwise. A spouse or a parent may act on an individual's behalf, including requesting access to their PHI. Please note that your spouse will be considered a Personal Representative unless you specifically make a request to the Fund Office not to disclose PHI to your spouse. All participants, including spouses and unemancipated minors, may request that the Plan restrict information that goes to family members by filling out a form to request restrictions on uses and disclosures of your PHI as described in this Notice. (*See "You May Request Restrictions on PHI Uses and Disclosures" on page 80*)

You should also review the Plan's Policy and Procedure for the Recognition of Personal Representatives for a more complete description of the circumstances where the Plan will automatically consider an individual to be a Personal Representative.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is required to give you access to certain PHI if you request it in order to allow you to inspect your individual privacy rights and/or copy it, or to provide an accounting to you, under certain circumstances as provided by law (see Section 3 of this Notice). Further descriptions of disclosures of your PHI for which consent, authorization and opportunity to object is not required are described in the Plan's policies and procedures.

The Plan is allowed under federal law to use and disclose your PHI without your consent or authorization, and without giving you an opportunity to object, under the following circumstances:

- As required by HHS. The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.
- For treatment, payment or health care operations. The Plan and its business associates may use PHI in order to carry out treatment, payment or health care operations.
    - Treatment is the provision, management or coordination of health care and related services with health care providers or other covered entities. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

      For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.
    - Payment includes, but is not limited to, actions to make eligibility or coverage determinations or undertake collection activities (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

      For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. If we contract with third parties to help us with payment

operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates."

- Health care operations includes, but is not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

  For example, the Plan may use information about your claims to refer you to a disease management program or a well-pregnancy program, to project future benefit costs or to audit the accuracy of its claims processing functions.

- Disclosure to the Plan's Trustees. The Plan may also disclose PHI to the Board of Trustees of the Northern Nevada Operating Engineers Health and Welfare Trust Fund (the "Plan Sponsor") for purposes related to, but not limited to, treatment, payment, and health care operations, and has amended the Plan Documents to permit this use and disclosure as required by federal law. For example, the Plan may disclose protected health information to the Board of Trustees of the Plan to allow them to decide an appeal of a benefit claim or for other reasons regarding the administration of this Plan, including review of a subrogation claim.

- When required by applicable law.

- Public health purposes. To an authorized public health authority if required by law or for public health and safety purposes. For example, the Plan may disclose your PHI when necessary to enable product recalls or repairs. The Plan may also use or disclose your PHI if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

- Domestic violence or abuse situations. If a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence, the Plan may report information about abuse, neglect or domestic violence to public authorities (1) when required by law; (2) if you agree to such disclosure; or (3) when the Plan is authorized by law and the disclosure is necessary to prevent serious harm to you or other potential victims. In such case, the Plan will promptly inform you or your Personal Representative that such a disclosure has been or will be made unless that would place you at a risk of serious harm or if the Plan would be informing a Personal Representative that it reasonably believes is responsible for the abuse. In the case of child abuse, it is not necessary for the Plan to inform the child of such disclosure.

- Health oversight activities. To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers); civil, administrative, or criminal proceedings or actions; and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).

- Legal proceedings. When required for judicial or administrative proceedings, as authorized by law. For example, your PHI may be disclosed in response to a subpoena or discovery request that is accompanied by a court order.

- Law enforcement health and emergency purposes. We may disclose PHI to law enforcement officials for the following purposes:

  a) When required for law enforcement purposes (for example, to report certain types of wounds or other physical injuries);

  b) Identifying or locating a suspect, fugitive, material witness or missing person;

  c) Disclosing information about an individual who is or is suspected to be a victim of a crime. This only applies if the Plan is unable to obtain the individual's agreement because of incapacity or other emergency circumstances;

- Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation and transplantation purposes.
- Funeral purposes. When required to be given to funeral directors to carry out their duties with respect to the decedent, after or in reasonable anticipation of the individual's death.
- Research. For research, subject to certain conditions.
- Health or safety threats. When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat or it is necessary for law enforcement authorities to identify or apprehend an individual.
- Workers' compensation programs. The Plan may disclose PHI to your employer and others, when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- Specialized government functions. When required, to military authorities under certain circumstances, or to authorized federal officials for lawful intelligence, counter intelligence and other national security activities.

Use or Disclosure of Your PHI To Relatives and Friends

Disclosure of your PHI to family members, other relatives, your close personal friends, and any other person you choose to identify is allowed under federal law if:

- The information is directly relevant to the family member, other relatives, or a close personal friend's involvement with your care or payment for that care, or
- The information is used or disclosed to notify, or assist in the notification of, a family member, Personal Representative, or another person responsible for your care, your location, general condition, or death.

If you are present for, or otherwise available prior to a use or disclosure permitted above, and you have the capacity to make health care decisions, the Plan will not use or disclose your PHI to your family and friends unless it:

- obtains your agreement,
- provides you with an opportunity to object to the use and disclosure of your PHI and you express no objections to such use and disclosure,
- the Plan can reasonably infer from the circumstances that you do not object to such use and disclosure,
- or pursuant to the Plan's policy on Personal Representatives, described in this Notice.

Other Uses or Disclosures: Written Authorization Required

The Plan may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Except as otherwise indicated in this Notice or as permitted by law, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization in writing.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include medication prescription or summary information about your mental health treatment. Although the 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. However, the Plan may use and disclose such notes when needed by the Plan to defend itself against litigation filed by you.

The Plan also requires your written authorization to share PHI with the companion pension plan or to administer any Life and Accidental Death and Dismemberment benefits you may apply for.

Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan may comply with your request at the discretion of the Plan Administrator or Privacy Official. The Plan is not required to agree to a requested restriction. If the Plan agrees to a restriction you have requested, it may terminate the restriction under certain circumstances. Make such requests in writing to:

The Privacy Officer: Jim Mace
Phone: (775) 826-7200
Northern Nevada Operating Engineers
Health and Welfare Trust Fund
445 Apple Street, Suite 109
Reno, NV 89502

You May Request Confidential Communications

The Plan will accommodate any individual's reasonable request to receive communications of his or her PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your Personal Representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Officer specified above.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a Designated Record Set (defined below) for as long as the Plan maintains the PHI.

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

The Plan must provide the requested information 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 the deadline.

You or your Personal Representative will be required to complete a form to request access to the PHI in your Designated Record Set. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Officer, specified above.

If access is denied, you or your Personal Representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Plan and the United States Department of Health and Human Services.

You Have the Right to Amend Your PHI

You or your Personal Representative have the right to request that the Plan amend your PHI or a record about you in the Designated Record Set for as long as the PHI is maintained in the Designated Record Set subject to certain exceptions. See the Plan's Right to Amend Policy for a list of exceptions.

You or your Personal Representative should make your request to amend PHI to the Privacy Officer, specified above. You or your Personal Representative will be required to complete a form provided by the Plan to request amendment of your PHI.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denies your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. 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 that PHI. You may also file a complaint with the Plan and/or HHS. See Section 5, below.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of certain disclosures of your PHI by the Plan. The Plan will not provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. See the Plan's Accounting for Disclosure Policy for the complete list of disclosures for which an accounting is not required.

You should direct your request to the Privacy Officer specified above.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Plan's Duties

Maintaining Your Privacy

The Plan is required by law to maintain the privacy of your PHI and to provide you with Notice of its legal duties and privacy practices.

Right to Amend

This Notice is effective beginning on April 14, 2003 and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI via mail.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this Notice.

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, 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 limitations.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Uses or disclosures made pursuant to your written authorization,
- Disclosures made to the Secretary of the United States Department of Health and Human Services pursuant to its enforcement activities under HIPAA,
- Uses or disclosures required by law, and
- Uses or disclosures required for the Plan's compliance with the HIPAA privacy regulations.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of:

The Privacy Officer: Jim Mace
Phone: (775) 826-7200
Northern Nevada Operating Engineers
Health and Welfare Trust Fund
445 Apple Street, Suite 109
Reno, NV 89502

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at www.hhs.gov, or contact the Privacy Officer for more information on how to file a complaint.

The Plan will not retaliate against you for filing a complaint.

If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Officer, specified above, at the Fund Office.

Conclusion

The federal Health Insurance Portability and Accountability Act, known as HIPAA, regulates PHI use and disclosure by the Plan. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede this Notice if there is any discrepancy between the information in this Notice and the regulations.

FACTORS THAT COULD AFFECT YOUR RECEIPT OF BENEFITS

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

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

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

GENERAL EXCLUSIONS, LIMITS, AND REDUCTIONS

The Fund will not provide benefits for the following:

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

- At least one-third of its gross income comes from donations or grants other than gifts or payments for patient care.
- It accepts patients who are unable to pay.
- Two-thirds of its patients have conditions directly related to the hospital's research.

- Work-related conditions if benefits are recovered or can be recovered under any workers' compensation, employer's liability, occupational disease, or similar law (If the right to recover such benefits is disputed, the Fund will provide benefits if you sign an agreement to prosecute a claim for such benefits diligently, consent to a lien by the Fund against your compensation for these benefits, and otherwise cooperate in securing reimbursement for the benefits provided.)
- Conditions caused by or arising out of
  - an act of war, armed invasion, or aggression
  - involvement in the commission of a felony, or
  - injuries an individual inflicts on himself, attempted suicide, or drug abuse, except as discussed in chapter 3 under "Mental Health" and "Chemical Dependency Treatment" in "Covered Services and Supplies"
- Except to the extent benefits are required by Federal law to be provided by the Fund, any services provided by a local, state, or Federal government agency, or any services for which payment may be obtained from any such agency (except Medicaid)
- Care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision
- Expenses incurred by an eligible individual due to driving in or being in actual physical control of a vehicle while having 0.08% or more by weight of alcohol in his or her blood or driving while having an amount of a prohibited substance in blood or urine that exceeds the legal limit of the jurisdiction.
- Any other expense specifically limited or excluded elsewhere in this booklet

YOUR RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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

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

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

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

Assistance with Your Questions

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

Assignment of Benefits

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

Authority

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

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

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

Right to Deductions from Future Benefits

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

Right to Examinations

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

Right to Freedom from Liability for Payment

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

No Replacement for Workers' Compensation

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

Not a Contract of Employment

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

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

PLAN FACTS

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

Administration of the Plan

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

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

The administrative office is staffed with persons competent in the fields of accounting, data processing, and claims processing. The contract administration organization bills all participating employers monthly, receives the employer contributions, maintains complete financial records, produces a monthly financial statement, maintains work records and eligibility records of all reported employees, and receives all claims filed by participating employees.

Trustees

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

Employee Trustees

John Bonilla
Operating Engineers Local 3
3920 Lennane Drive
Sacramento, CA 95834

T. Robert Miller
Operating Engineers Local 3
3920 Lennane Drive
Sacramento, CA 95834

Frank Herrera
Operating Engineers Local 3
3920 Lennane Drive
Sacramento, CA 95834

Chuck Billings
Operating Engineers Local 3
1290 Corporate Boulevard
Reno, NV 89502

Employer Trustees

Carlo Panicari, Chairman
President, Panicari Construction Company
4740 Plumas Street
Reno, NV 89509

Norman L. Dianda
President, Q & D Construction
1050 S. 21st Street
Sparks, NV 89431

John Madole
Manager, Associated General Contractors
P.O. Box 10865
Reno, NV 89510

Funding Arrangements and Organizations Through Which Benefits Are Provided

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

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

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

Benefit Plan Administrators, Inc.
Healthcare Services Department
P.O. Box 11337
Reno, Nevada 89510-1337
(administers Contract Provider program and utilization management program)

American Diversified Pharmacies
3920 Lennane Drive, Suite 100
Sacramento, CA 95834
(administers the mail order prescription drug program)

RxAmerica
221 N Charles Lindbergh Dr.
Salt Lake City, Utah 84116
(administers the retail prescription drug program)

ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

The Union Labor Life Insurance Company
1625 Eye Street, NW
Washington, D.C. 20001
(provides fully insured burial expense benefit)

Plan Documents

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

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

Collective Bargaining Agreements

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

Future of the Plan and Trust Fund

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

Plan Amendment or Termination

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

This right includes, but is not limited to,

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

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

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

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

GLOSSARY OF TERMS USED IN THE SPD

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

Addiction Recovery Program (ARP). The program that coordinates services for the treatment of substance abuse for employees and dependent spouses.

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

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

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

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

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

Contract hospital. A hospital that has a contract in effect with the Fund under the Preferred Provider Plan.

Contract Provider. A Physician or Allied Health Practitioner, laboratory or radiology facility, free-standing surgical facility or provider of durable medical equipment that has a contract in effect with the Fund under the Preferred Provider Plan. Contract Provider shall also include an ophthalmologist, optometrist or optician with who has a contract in effect with the Fund with respect to services covered under the Vision Care Benefits. Contract Provider shall also include a Dentist who has a contract in effect with the Fund with respect to services covered under the Dental Benefits.

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

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

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

- Reasonable charges, as defined
- The negotiated rate for services of a Contract Hospital or Contract Provider;
- The Scheduled Allowance for services of a Non-Contract Hospital or Non-Contract Provider;

- The contract rate between the health care provider and a plan with which this Plan is coordinating benefits.

Customary charges. See "Reasonable charges."

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

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

Emergency. 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..

Experimental. A medical, surgical, diagnostic, psychiatric, substance abuse, or other health care service, technology, supply, treatment, procedure, drug therapy, or device of which, in the opinion of the Plan Administrator or its designee, ***any*** of the following was true regarding one or more essential provisions when it was provided or performed (based on the information and resources then available):

- The prescribed service or supply could be given only with the approval of an Institutional Review Board as defined by Federal law.

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

  Authoritative peer-reviewed medical or scientific writings that will be considered include the "United States Pharmacopeia Dispensing Information"; "American Hospital Formulary Service"; "American Medical Association (AMA) Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program" or similar publications of the AMA; specialty organizations recognized by the AMA; the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Agency for Health Care Policy and Research (AHCPR); other agency review organizations such as ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries; the American Dental Association (ADA), with respect to dental services or supplies; and the latest edition of "The Medicare Coverage Issues Manual."

- Food and Drug Administration (FDA) approval was required for the service and supply to be lawfully marketed and it had not been granted at the time the service or supply was prescribed or provided or a current investigational new drug or new device application had been submitted and filed with the FDA.

  (However, a drug will NOT be considered experimental and/or investigational if it has been approved by the FDA as an "investigational new drug for treatment use"; classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and prescribed for the treatment of a type of cancer for which it was not approved for general use, provided the FDA has not determined that such drug should not be prescribed for a given type of cancer.)

- The prescribed service or supply was available to the covered individual only through participation in Phase I or Phase II clinical trials or through Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

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

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

Group plan. Any plan providing benefits of the type provided by this Plan that is supported wholly or in part by employer payments.

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

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

Hospital. Any acute care hospital that is licensed under any applicable state statute and must provide 24-hour inpatient care and the following basic services on the premises: medical, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

Illness. A bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same causes. The term "Illness" shall also include pregnancy.

Injury. Physical harm sustained as the direct result of an accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Investigational. See "experimental."

Licensed pharmacist. A person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Local Union. Operating Engineers Local Union No. 3 of the International Union of Operating Engineers.

Medically necessary. A service or supply that is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it and is determined by the Plan Administrator or its designee to meet ***all*** of the following requirements:

- It is consistent with the symptoms or diagnosis and treatment of the illness or injury,
- It is not provided primarily for the convenience of the patient, physician, hospital or health care facility, or other health care provider,
- It is an "appropriate" service or supply (*see definition earlier in glossary*), given the patient's circumstances and condition,
- It is a **"**cost-efficient**"** supply or level of service (*see definition earlier in glossary*) that can be safely provided to the patient, and
- It is safe and effective for the illness or injury for which it is used.

The fact that the physician may provide, order, recommend, or approve a service or supply does not mean that the service or supply will be considered medically necessary for the medical coverage provided by the Plan. A hospitalization or confinement to a skilled nursing facility or other specialized health care facility will NOT be considered medically necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated without the patient's being confined.

Medicare. The benefits provided under Title XVIII of the Social Security Amendments of 1965.

Non-Contract Hospital. A hospital that does not have a contract in effect with the Fund under the Preferred Provider Plan.

Non-contracting provider. Any Physician or Allied Health Practitioner, laboratory or radiology facility, free-standing surgical facility or provider of durable medical equipment that does not have a contract in effect with the Fund under the Preferred Provider Plan. Non-Contract Provider shall also include an ophthalmologist, optometrist or optician with who does not have a contract in effect with the Fund with

respect to services covered under the Vision Care Benefits. Contract Provider shall also include a Dentist who does not have a contract in effect with the Fund with respect to services covered under the Dental Benefits.

Patient. The eligible individual who is receiving medical treatment, services, or supplies covered by the Plan.

Physician. A physician and surgeon (M.D.), an osteopath (D.O.), or a dentist (D.D.S. or D.M.D.) licensed to practice medicine in the state in which he or she practices.

Plan. The "Plan" means the Rules and Regulations of the Direct Payment Plan and any amendments to it.

Pre-existing medical condition. A condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six months preceding the individual's enrollment date for this Plan. Any exclusion or limitation for a pre-existing medical condition will not apply to pregnancy-related expenses or to newborns or children who are adopted or enrolled in the Plan within 30 days of the birth or adoption. The maximum duration for which a pre-existing medical condition may be excluded is 12 months, reduced by the period of creditable coverage the individual has as of his enrollment date.

Preferred Provider Plan. A program whereby hospitals, laboratory/radiology facilities, and physicians and Allied Health Practitioners and other health care facilities contract with the Fund to provide necessary hospitalization and medical services to eligible individuals at a negotiated rate, approved by the Board and amended from time to time.

Preferred Provider Plan Service Area. The area within the State of Nevada where eligible individuals who live there are subject to the reimbursement provisions of the Preferred Provider Plan.

Professional review organization (PRO). An organization under contract to the Fund that is responsible for determining the medical necessity of services and supplies.

Reasonable charges. A **"reasonable charge"** means the usual or customary charge in the area in which it is incurred, but not exceeding the charge that would have been made in the absence of the benefits provided under the Rules and Regulations. A **"customary charge"** means a charge that falls within the common range of fees billed by a majority of physicians for a procedure in a given geographic area or that is justified based on the complexity or the severity of treatment for a specific care, as determined from time to time by the Board. The term "area," as it would apply to any particular item for which a covered charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of persons, hospitals, prescription pharmacies, institutions, or other entities furnishing the item.

Reciprocity Agreement. The agreement that establishes the administrative procedures for reciprocity between the funds signatory to the Western Conference of Operating Engineers Health and Welfare Reciprocity Agreement and any modification, amendment, extension, or renewal thereof.

Retired employee. A person receiving a pension from the Pension Trust Fund for Operating Engineers. A person who continues to be an employee after reaching age 70-1/2 and is receiving a pension as required by Section 401(a)(9)(c) of the Internal Revenue Code shall not be considered a retired employee until such time as he no longer meets the eligibility requirements discussed in chapter 2 of this booklet.

Schedule of allowances. 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. The schedule of allowances provides specific reimbursement levels depending on whether benefits are due for services received from a Contract Hospital or Contract Provider, or a non-Contract Hospital or non-Contract Provider.

Totally disabled. Unable, due to illness, disease, injury, or pregnancy, to perform substantially all of the material duties of the occupation in which you were engaged prior to disability and not engaged in any gainful occupation. For purposes of extended employee life insurance coverage, "totally disabled" means that you are unable, due to illness or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

Trust Agreement. The Trust Agreement establishing the Northern Nevada Operating Engineers Health and Welfare Trust Fund and any modification, amendment, extension, or renewal thereof.

Utilization Review (UR) Program. A program whereby the professional review organization (PRO) under contract to the Fund determines the medical necessity of services and supplies. The UR representative also handles urgent care claims for medical care and confirms whether a hospital, physician, or other health care provider is a Contract Provider.