



U.A. Local 350 Health, Welfare and Vacation Plan

Coverage for: FAMILY| Plan Type: Indemnity

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the Trust Fund Office at 1-775-826-7200. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-775-826-7200 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$270/Individual or \$750/Family.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , three family members must meet their own individual <u>deductible</u> before the family <u>deductible</u> of \$750.00 is met.
Are there services covered before you meet your deductible?	Yes. Certain <u>Preventive care</u> , specific <u>outpatient lab procedures</u> (performed in Lab Corp. or Quest labs), and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ but contact the Trust Fund Office for specific covered <u>preventive services</u> under this <u>plan</u> .
Are there other deductibles for specific services?	Yes. \$10 for <u>prescription drug coverage</u> and \$100/individual and \$300/family for <u>dental expenses</u> . There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$2,000/ Individual; for <u>out-of-network providers</u> No Limit/ Individual.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, <u>deductibles</u> , mail order and <u>prescription drug charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. Call 1-775-826-7200 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>) subject to this <u>plan's Schedule of Allowance</u> . Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without permission from this <u>plan</u> .

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (You will pay the most)	
<p>If you visit a health care provider's office or clinic</p>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
	Specialist visit	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. Chiropractic care (25 visits/year). Acupuncture (15 visits/year).
	Preventive care/screening/immunization	20% <u>coinsurance</u> of PPO contract rate but Annual physical exam covered at No Charge, deductible does not apply for employee & spouse only. (No Cost for Covid-19 vaccinations)	30% <u>coinsurance</u> subject to non-PPO fee schedule but Annual physical exam covered at No Charge plus subject to non-PPO fee schedule, deductible does not apply for employee & spouse only. (No Cost for Covid-19 vaccinations)	Deductible applies to well child care (including routine diagnostic testing or vaccinations up to age 19). Annual physical exam including expenses for radiology and lab testing covered at 100% and limited to one exam/year for employee and spouse only. Colonoscopy limited to age 50 and older. Plan will pay flu shots up to \$33 per year per participant or dependent and any amount in excess of \$33 are your responsibility (subject to coinsurance). During public health emergency period no cost-sharing for coverage of COVID-19 vaccinations and no prior auth. required.
	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u> after deductible (no deductible if received at LabCorp. & Quest); No Charge if radiology and lab test for Annual physical exam. (No Cost for Covid-19 Testing).	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule but No Charge plus subject to non-PPO fee schedule if radiology or lab test for Annual physical exam. (No Cost for Covid-19 Testing).	Radiology and lab tests for Annual physical exam and Services received at LabCorp and Quest covered 100% of PPO contract rate plus deductible does not apply. During public health emergency period only, COVID-19 testing and screening is covered at no cost.
<p>If you have a test</p>	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Preauthorization is required by Professional Review Organization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com or call 1-800-797-9791.	Generic drugs	\$10 <u>copay</u> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <u>copay</u> plus non-covered charge (retail).	Covers up to a 34-day supply and must pay discounted price at time of purchase (retail subscription); up to 90 day supply for maintenance drugs, equal \$30 <u>copay</u> (mail order prescription). <u>Specialty drugs</u> requires <u>preauthorization</u> .
	Preferred brand drugs	\$10 <u>copay</u> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <u>copay</u> plus non-covered charge (retail).	
	Non-preferred brand drugs	\$10 <u>copay</u> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <u>copay</u> plus non-covered charge (retail).	
	<u>Specialty drugs</u>	\$10 <u>copay</u> /prescription (retail & mail order)	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after <u>deductible</u> plus \$25 <u>copay</u> /visit	30% <u>coinsurance</u> after <u>deductible</u> plus \$25 <u>copay</u> /visit	6 visits/year. During public health emergency period, COVID-19 treatment covered in same manner as other medically necessary treatment per Plan rules.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
	<u>Urgent care</u>	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	<u>Preauthorization</u> is required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> of PPO contract rate after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	See Sections 3.9 and 3.11 of SPD/Plan Document for more information on limitations.
	Inpatient services	20% <u>coinsurance</u> of PPO contract rate after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	<u>Preauthorization</u> is required by Professional Review Organization. No visit or confinement limits.
If you are pregnant	Office visits	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	Coverage does not apply to dependent daughter. Limited to allowed amount under
	Childbirth/delivery	20% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u> subject to non-PPO fee schedule	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Network Provider (You will pay the least)	Non-PPO Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	professional services			PPO contract rate or Non-PPO fee schedule. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services			
	<u>Home health care</u>	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	100 visits/year. Nutritional counseling maximum benefit is \$50/year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Physical therapy limited to 30 visits/year as medically necessary.
	<u>Habilitation services</u>	20% <u>coinsurance</u> of PPO contract rate after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Effective January 1, 2020, autism is covered including physical therapy, psychotherapy, applied behavioral analysis and inpatient treatment if medically necessary. <u>Preauthorization</u> is required for inpatient services.
	<u>Skilled nursing care</u>	50% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Maximum 100 days. Successive periods of confinement must be separated by 30 days.
	<u>Durable medical equipment</u>	0 - 20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Must be medically necessary plus requires doctor's order and rental to purchase.
	<u>Hospice services</u>	20% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible subject to non-PPO fee schedule	Annual maximum of \$7,500.
	Children's eye exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No deductible. Limited to 1 exam/year.
	Children's glasses	20% <u>coinsurance</u>	20% <u>coinsurance</u>	No deductible. Limited to 1 pair glasses/year.
If your child needs dental or eye care	Children's dental check-up	5% <u>coinsurance</u> of PPO rate; <u>deductible</u> does not apply.	5% <u>coinsurance</u> of dental non-PPO fee schedule; <u>deductible</u> does not apply.	No annual maximum if under age 19 but \$2,500 maximum if over age 19 through age 25. Dental <u>deductible</u> does not apply for routine dental check-up. See Article VIII of SPD/Plan Document for more information on limitations.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---------------------|-------------------------|--|
| • Cosmetic Surgery | • Infertility Treatment | • Non-emergency care when traveling outside the U.S. |
| • Bariatric Surgery | • Long Term Care | • Routine Foot Care |
| | • Private Duty Nursing | • Weight Loss Programs |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|---|--|
| • Acupuncture (15 visits/year if provided by physician or certified acupuncturist) | • Dental & Orthodontic Care (Adult & Dependents) | • Routine eye care (Adults & Dependents) |
| • Chiropractic Care (25 visits/year for vertebrae, spine, back and neck only) | • Hearing Aids (Up to a maximum of \$1,000 per ear in any 4-year period.) | • Smoking Cessation Program |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact **Benefit Plan Administrators** at 1-775-826-7200 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

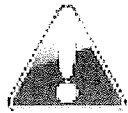
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-775-826-7200.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$270
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$270
<u>Copayments</u>	None
<u>Coinsurance</u>	\$2,000

What isn't covered

Limits or exclusions \$0

The total Peg would pay is \$2,270

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$270
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

Total Example Cost \$7,400

In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$270
<u>Copayments</u>	None
<u>Coinsurance</u>	\$1426

What isn't covered

Limits or exclusions \$0

The total Joe would pay is \$1,696

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$270
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

Total Example Cost \$1,900

In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$270 + \$25
<u>Copayments</u>	None
<u>Coinsurance</u>	\$321

What isn't covered

Limits or exclusions \$0

The total Mia would pay is \$616