



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

 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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> 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).
	<a href="#">Preventive care/screening/immunization</a>	20% <a href="#">coinsurance</a> of PPO contract rate but Annual physical exam covered at No Charge, <a href="#">deductible</a> does not apply for employee & spouse only. ( <a href="#">No Cost for Covid-19 vaccinations</a> )	30% <a href="#">coinsurance</a> subject to non-PPO fee schedule but Annual physical exam covered at No Charge plus subject to non-PPO fee schedule, <a href="#">deductible</a> does not apply for employee & spouse only. ( <a href="#">No Cost for Covid-19 vaccinations</a> )	<a href="#">Deductible</a> 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). <b>During public health emergency period no cost-sharing for coverage of COVID-19 vaccinations inc. booster shots and no prior auth. required.</b>
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> (no <a href="#">deductible</a> if received at LabCorp. & Quest); No Charge if radiology and lab test for Annual physical exam. ( <a href="#">No Cost for Covid-19 Testing</a> ).	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> 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. ( <a href="#">No Cost for Covid-19 Testing</a> ).	Radiology and lab tests for Annual physical exam and Services received at LabCorp and Quest covered 100% of PPO contract rate plus <a href="#">deductible</a> does not apply. <b>During public health emergency period only, COVID-19 testing and screening is covered at no cost.</b>
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	<a href="#">Preauthorization</a> is required by Professional Review Organization.

\* For more information about limitations and exceptions, see the plan or policy document at [ualocal350.org/benefits-office.aspx](http://ualocal350.org/benefits-office.aspx).

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1-800-797-9791.	Generic drugs	\$10 <a href="#">copay</a> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <a href="#">copay</a> 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 <a href="#">copay</a> (mail order prescription). <a href="#">Specialty drugs</a> requires <a href="#">preauthorization</a> .
	Preferred brand drugs	\$10 <a href="#">copay</a> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <a href="#">copay</a> plus non-covered charge (retail).	
	Non-preferred brand drugs	\$10 <a href="#">copay</a> /prescription (retail & mail order)	Not Covered (mail order); After \$10 <a href="#">copay</a> plus non-covered charge (retail).	
	<a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> /prescription (retail & mail order)	Not Covered.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except for No Surprises Act covered items and services same as <a href="#">network provider</a> .	<a href="#">Preauthorization</a> is required. Certain <b>non-emergency services &amp; ancillary services</b> (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by <a href="#">out-of-network provider</a> at ambulatory surgery center you cannot be billed more than the plan's <a href="#">network</a> contract rate. However, there are certain other non-emergency services at these <a href="#">network</a> facilities, you can give written consent to be <a href="#">balance billed</a> . Contact the Trust Fund Office for more information.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except for No Surprises Act covered items and services same as <a href="#">network provider</a> .	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a> plus \$25 <a href="#">copay</a> /visit	Per No Surprises Act, same as <a href="#">network provider</a> 20% <a href="#">coinsurance</a> after <a href="#">deductible</a> plus \$25 <a href="#">copay</a> /visit	No. <a href="#">Pre-authorization</a> required & No <a href="#">balance billing</a> . During public health emergency period, COVID-19 treatment covered in same manner as other medically necessary treatment per Plan rules. Any cost-sharing will count towards any Plan

\* For more information about limitations and exceptions, see the plan or policy document at [ualocal350.org/benefits-office.aspx](http://ualocal350.org/benefits-office.aspx).

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)	
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	For Ground Ambulance, 30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except Covered Air Ambulance same as <a href="#">network provider</a> .  For Urgent care, per No Surprises Act same as <a href="#">network provider</a> .	applicable <a href="#">deductible</a> or <a href="#">out-of-pocket limit</a> . For <a href="#">recognized amount</a> see Plan Rules. Emergency includes treatment received in Independent Free standing emergency department.
	<a href="#">Urgent care</a>			For Non-PPO Covered Air Ambulance and Urgent Care, any cost-sharing will count towards any Plan applicable <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> and No <a href="#">balance billing</a> .  For Non-PPO Ground Ambulance, limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except for No Surprises Act covered items and services same as <a href="#">network provider</a> .	<a href="#">Preauthorization</a> is required. Certain <b>non-emergency services &amp; ancillary services</b> (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by <a href="#">out-of-network provider</a> at ambulatory surgery center you cannot be billed more than the plan's <a href="#">network</a> contract rate. However, there are certain other non-emergency services at these <a href="#">network</a> facilities, you can give written consent to be <a href="#">balance billed</a> . Contact the Trust Fund Office for more information.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except for No Surprises Act covered items and services same as <a href="#">network provider</a> .	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.

\* For more information about limitations and exceptions, see the plan or policy document at [ualocal350.org/benefits-office.aspx](http://ualocal350.org/benefits-office.aspx).

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> of PPO contract rate after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	See Sections 3.9 and 3.11 of SPD/Plan Document for more information on limitations. <a href="#">Out-of-network emergency services</a> covered same as <a href="#">network</a> provider.
	Inpatient services	20% <a href="#">coinsurance</a> of PPO contract rate after <a href="#">deductible</a>	30 <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	<a href="#">Preauthorization</a> is required by Professional Review Organization. No visit or confinement limits. <a href="#">Out-of-network emergency services</a> covered same as <a href="#">network</a> provider.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule except emergency services per No Surprises Act same as <a href="#">network provider</a> .	Coverage does not apply to dependent daughter. Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <a href="#">Out-of-network emergency services</a> covered same as <a href="#">network</a> provider.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	100 visits/year. Nutritional counseling maximum benefit is \$50/year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Physical therapy limited to 30 visits/year as medically necessary.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> of PPO contract rate after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Autism is covered including physical therapy, psychotherapy, applied behavioral analysis and inpatient treatment if medically necessary. <a href="#">Preauthorization</a> is required for inpatient services.
	<a href="#">Skilled nursing care</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Maximum 100 days. Successive periods of confinement must be separated by 30 days.
	<a href="#">Durable medical equipment</a>	0 - 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Must be medically necessary plus requires doctor's order and rental to purchase.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	30% <a href="#">coinsurance</a> after <a href="#">deductible</a> subject to non-PPO fee schedule	Annual maximum of \$7,500.
If your child needs dental or eye care	Children's eye exam	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	No deductible. Limited to 1 exam/year.
	Children's glasses	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	No deductible. Limited to 1 pair glasses/year.

\* For more information about limitations and exceptions, see the plan or policy document at [ualocal350.org/benefits-office.aspx](http://ualocal350.org/benefits-office.aspx).



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)	
	Children's dental check-up	5% <a href="#">coinsurance</a> of PPO rate; <a href="#">deductible</a> does not apply.	5% <a href="#">coinsurance</a> of dental non-PPO fee schedule; <a href="#">deductible</a> does not apply.	No annual maximum if under age 19 but \$2,500 maximum if over age 19 through age 25. Dental <a href="#">deductible</a> 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](#).)

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Bariatric Surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Long Term Care</li> <li>• Private Duty Nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul> |
|---|---|---|

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

- |   |   |   |
|---|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture (15 visits/year if provided by physician or certified acupuncturist)</li> <li>• Chiropractic Care (25 visits/year for vertebrae, spine, back and neck only)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental &amp; Orthodontic Care (Adult &amp; Dependents)</li> <li>• Hearing Aids (Up to a maximum of \$1,000 per ear in any 4-year period.)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adults &amp; Dependents)</li> <li>• Smoking Cessation Program</li> </ul> |
|---|---|---|

**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](http://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](http://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](http://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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$270
<a href="#">Copayments</a>	None
<a href="#">Coinsurance</a>	\$2,000
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,270</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$270
<a href="#">Copayments</a>	None
<a href="#">Coinsurance</a>	\$1426
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,696</b>

**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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$270 + \$25
<a href="#">Copayments</a>	None
<a href="#">Coinsurance</a>	\$321
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$616</b>