U.A. LOCAL 350 HEALTH, WELFARE & VACATION TRUST FUND
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February 2018

TO: **PARTICIPANTS & DEPENDENTS**

RE: **SUMMARY OF MATERIAL MODIFICATIONS ("SMM") and MODIFICATION TO SUMMARY OF BENEFITS & COVERAGE ("SBC") for U.A. Local 350 Health and Welfare Plan**

The Board of Trustees of the U.A. Local 350 Health and Welfare Plan ("Plan") is pleased to provide you with the following summary of changes to the Plan. IN ACCORDANCE WITH THE REQUIREMENTS OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, AS AMENDED ("ERISA"), THIS DOCUMENT SERVES AS A SUMMARY OF MATERIAL MODIFICATIONS ("SMM") TO THE PLAN AND SUPPLEMENTS THE RESTATED SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT THAT HAS BEEN SEPARATELY PROVIDED TO YOU. YOU SHOULD RETAIN THIS DOCUMENT WITH YOUR COPY OF THE RESTATED SUMMARY PLAN DESCRIPTION/PLAN DOCUMENT.

We have also attached a revised Summary of Benefits & Coverage ("SBC") to reflect the new benefits enhancements. Please see enclosure.

Please contact the Plan Office at 775-826-7200, if you have any questions.

BENEFIT CHANGES

Effective March 1, 2018 (unless another effective date is mentioned), the following benefit enhancements have been made to the Plan:

- For **Orthodontic benefits,** the following limits and cost-sharing have been changed to the Plan's Section 8.07, Article VIII:

ADULT (employee & spouse)	
Lifetime Maximum	*$1,500*
Banding Fee Limit	*$500*
In-Network	*Paid at 80% (you are responsible for 20%)*
Out-of-Network	*Paid at 80% (you are responsible for 20%)*

DEPENDENT CHILDREN (up to age 26)	
Lifetime Maximum	*$2,500* (previously $1,250)
Banding Fee Limit	*$500*
In-Network	*Paid at 80% (you are responsible for 20%)*
Out-of-Network	*Paid at 80% (you are responsible for 20%)*

As a reminder there is no deductible for Orthodontic Benefits.

- **A new Hearing Aid Benefit** has been added to the Plan as Section 3.30, Article III as follows:

HEARING AID BENEFIT (must be medically necessary)	
Limit	*Up to maximum of $1,000 per ear in any 4 year period.*
Deductible	*No Deductible is applied.*
In-Network	*Paid at 90% (you are responsible for 10%)*
Out-of-Network	*Paid at 90% (you are responsible for 10%)*

- For **Inpatient Mental Health Benefits** the "60 days per 24 months" limit has been eliminated effective **January 1, 2018**.

- For **Treatment of Alcohol or Substance Abuse** the "one detox treatment per calendar year" and "one inpatient confinement per calendar year per participant up to 28 day" limit have both been eliminated effective **January 1, 2018**.

GRANDFATHERED HEALTH PLAN REMINDER

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

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

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

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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
	Specialist visit	20% coinsurance after deductible	30% coinsurance 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% coinsurance of PPO contract rate but Annual physical exam covered at No Charge, deductible does not apply for employee & spouse only.	30% coinsurance 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.	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible (no deductible if received at LabCorp. & Quest); No Charge if radiology and lab test for Annual physical exam.	30% coinsurance 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.	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.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Preauthorization is required by Professional Review Organization.
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 copay/prescription (retail & mail order)	Not Covered (mail order); After $10 copay 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 copay (mail order prescription). Specialty drugs requires preauthorization.
	Preferred brand drugs	$10 copay/prescription (retail & mail order)	Not Covered (mail order); After $10 copay plus non-covered charge (retail).	
	Non-preferred brand drugs	$10 copay/prescription (retail & mail order)	Not Covered (mail order); After $10 copay plus non-covered charge (retail).	
	Specialty drugs	$10 copay/prescription (retail & mail order)	Not Covered.	

* For more information about limitations and exceptions, see the plan or policy document at 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible 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	Emergency room care	20% coinsurance after deductible plus $25 copay/visit	30% coinsurance after deductible plus $25 copay/visit	6 visits/year.
	Emergency medical transportation	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Limited to allowed amount under PPO contract rate or Non-PPO fee schedule.
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible 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% coinsurance of PPO contract rate after deductible	30% coinsurance after deductible 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% coinsurance of PPO contract rate after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Preauthorization is required by Professional Review Organization. **Effective 1/1/2018 there are no visit or confinement limits**.
If you are pregnant	Office visits	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	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).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	100 visits/year. Nutritional counseling maximum benefit is $50/year.
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Physical therapy limited to 30 visits/year.
	Habilitation services	Not Covered.	Not Covered.	None.
	Skilled nursing care	50% coinsurance after deductible	50% coinsurance after deductible subject to non-PPO fee schedule	Maximum 100 days. Successive periods of confinement must be separated by 30 days.
	Durable medical equipment	0 - 20% coinsurance	30% coinsurance after deductible	Must be medically necessary plus requires

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)	
		after deductible	subject to non-PPO fee schedule	doctor's order and rental to purchase.
	Hospice services	20% coinsurance after deductible	30% coinsurance after deductible subject to non-PPO fee schedule	Annual maximum of $7,500.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	No deductible. Limited to 1 exam/year.
	Children's glasses	20% coinsurance	20% coinsurance	No deductible. Limited to 1 pair glasses/year.
	Children's dental check-up	5% coinsurance of PPO rate; deductible does not apply.	5% coinsurance of dental non-PPO fee schedule; deductible does not apply.	No annual maximum if under age 19 but $2,500 maximum if over age 19. Dental deductible 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
- Bariatric Surgery
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture (15 visits/year if provided by physician or certified acupuncturist)
- Chiropractic Care (25 visits/year for vertebrae, spine, back and neck only)
- Dental Care (Adult & Dependents)
- **Hearing Aids (Effective March 1, 2018, up to a maximum of $1,000 per ear in any 4 year period.)**
- Routine eye care (Adults & Dependents)

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.

* For more information about limitations and exceptions, see the plan or policy document at ualocal350.org/benefits-office.aspx.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

* For more information about limitations and exceptions, see the plan or policy document at ualocal350.org/benefits-office.aspx.

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	
Deductibles	$270
Copayments	$
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$
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	
Deductibles	$270
Copayments	$
Coinsurance	$1426
What isn't covered	
Limits or exclusions	$
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	
Deductibles	$270 + $25
Copayments	$
Coinsurance	$321
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$616**

The plan would be responsible for the other costs of these EXAMPLE covered services.