# Northern Nevada Laborers Health & Welfare Trust Fund



**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, 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?** | **$350** Individual/No Family Ded. Doesn't apply to: routine preventive care (for member only on preventative), specific outpatient laboratory procedures performed in Lab Corp, Quest or Renown labs, or mail order prescription drugs. | You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over (usually, but not always, January 1st). |
| **Are there services covered before you meet your deductible?** | **Yes.** Certain Preventive care, specific outpatient lab procedures (performed in Lab Corp, Quest or Renown labs), and prescription drugs are covered after you meet your deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But 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.** $100 deductible for each emergency room visit. | You don't have to meet deductibles for specific services. There is a $100 deductible for each emergency room visit. |
| **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, except for all emergency room visits. |
| **What is not included in the out-of-pocket limit?** | Balance-billed charges, health care this plan doesn't cover, copayments, deductibles and non PPO charges. | See your plan document or summary plan description for a description of services and supplies that are not covered and expenses subject to "Exclusions From Coverage." |
| **Will you pay less if you use a network provider?** | **Yes.** Call **1-775-826-7200** for a list of network providers, or visit 169laborers.com for a list as well. | 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 **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 | 40% coinsurance after deductible subject to non-PPO fee schedule | Telemedicine with a Renown healthcare provider or specialist via telemedicine (rather than having you travel to that provider) is covered subject to normal benefits when initiated through a Renown Telehealth location. |
| | Specialist visit | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. Chiropractic care (30 visits/year). Acupuncture (15 visits/year). |
| | Preventive care/screening/ immunization | Employee & Spouse and Dependents under at 19. Covered at 100%, deductible does not apply. Routine Pap smear and pelvic exam, 100%, no deductible applied, Routine Mammogram over age 35, covered at 100%, no deductible applied. | 40% 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 only. | Deductible does not applies to well child care (including routine diagnostic testing or vaccinations up to age 19). School physicals for sports are covered at no charge PPO and max of $70.00 for Non-PPO. Annual exams including expenses for radiology , 1 basic x-ray, one EKG, 1 coronary calcium CT, and maximum of 10 lab procedures covered at 100% and limited to one type of exam/year for employee and Dependent Spouse. Colonoscopy is limited to age 45 and older, once every 5 years. Annual routine mammogram covered for women over age 35 and annual routine pap smear & pelvic exam covered as Annual Physical exam. Shingles vaccine covered up to $172.00 per shot based on CDC guidelines, RSV vaccines covered up to $20.00 per FDA approved vaccine on annual basis and flu vaccines covered up to $224.00 per FDA approved vaccine as preventive services or |

| 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) | |
| | | | | medical necessity per doctor's order. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible (no deductible or coinsurance if received at LabCorp, Quest or Renown); No Charge if radiology and lab test for Annual physical exam for employee only. | 40% 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, Quest or Renown covered 100% of PPO contract rate. Deductible does not apply to lab. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Preauthorization is required. |
| **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 | 20% coinsurance after deductible | 40% coinsurance up to Non-PPO allowed amount | Retail: Covers up to 60 day supply If generic is available participant must get it. If a brand drug is purchased then it will be cut back to the generic cost when a generic is available. Mail Order: Covers up to 90 day supply for maintenance drugs. If generic is available participant must get it. If a brand drug is purchased then it will be cut back to the generic cost when a generic is available. |
| | Preferred brand drugs | 20% coinsurance after deductible | 40% coinsurance up to Non-PPO allowed amount | |
| | Non-preferred brand drugs | 20% coinsurance after deductible | 40% coinsurance up to Non-PPO allowed amount | |
| | Specialty drugs | 20% coinsurance after deductible | Not Covered. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule except for No Surprises Act covered services same as Network provider | Preauthorization is required. Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. Certain **non-emergency services** & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at ambulatory surgery center you cannot be billed more than the |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule except for No Surprises Act covered services same as Network provider | |

| 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) | |
| | | | | plan's network contract rate. However, there are certain other non-emergency services at these network facilities, you can give written consent to be balance billed. |
| **If you need immediate medical attention** | Emergency room care | $100.00 deductible plus 20% coinsurance of PPO contract rate after deductible met | Per No Surprises Act, same as network provider. | Limited to allowed amount PPO provider contract rate or Non-PPO fee schedule. Emergency includes treatment received in Independent Free standing emergency department. Emergency room expenses will apply to out-of-pocket limit. |
| | Emergency medical transportation | 20% coinsurance after deductible | For Ground Ambulance, 40% coinsurance after deductible subject to non-PPO fee schedule | Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. You pay 20% coinsurance for covered Non-PPO air ambulance services and there will be no balance billing from the Non-PPO provider per No Surprise Act. |
| | Urgent care | | | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule except for No Surprises Act covered services same as Network provider. | Preauthorization is required. Limited to allowed amount under PPO contract rate or Non-PPO fee schedule. Certain **non-emergency services** & ancillary services (ex. emergency medicine, anesthesia, pathology, radiology, lab, neonatology, assistant surgeon, hospitalist or intensivist services) received by out-of-network provider at network hospital you cannot be billed more than the plan's network contract rate. However, there are certain other non-emergency services at these network facilities, you can give written consent to be balance billed. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule except for No Surprises Act covered services same as Network provider. | |

| 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% coinsurance of PPO contract rate after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | See pages 33-34 of SPD for more information on limitations. Per No Surprises Act, if emergency situation non-PPO provider covered the same as network provider. |
| | Inpatient services | 20% coinsurance of PPO contract rate after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Preauthorization is required. See SPD for more details. Per No Surprises Act, if emergency situation non-PPO provider covered the same as network provider. |
| **If you are pregnant** | Office visits<br>Childbirth/delivery professional services<br>Childbirth/delivery facility services | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule except for No Surprise Act covered services same as PPO Network provider. | 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). No Preauthorization is required for epidural. |
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Pre-Authorization Required. Limited to allowed amount PPO provider contract rate or Non-PPO fee schedule. |
| | Rehabilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Physical therapy limited to 30 visits/year. |
| | Habilitation services | 20% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Precertification is required for inpatient services. |
| | Skilled nursing care | 50% coinsurance after deductible | 50% coinsurance after deductible subject to non-PPO fee schedule | Pre-Authorization Required. Limited to allowed amount PPO provider contract rate or Non-PPO fee schedule.. |
| | Durable medical equipment | 10% coinsurance after deductible | 40% coinsurance after deductible subject to non-PPO fee schedule | Must be medically necessary plus requires doctor's order and rental to purchase. |
| | Hospice services | 10% coinsurance after deductible | 50% coinsurance after deductible subject to non-PPO fee schedule | No limit. No Pre-Authorization required. |
| **If your child needs dental or eye care** | Children's eye exam, under age 19. | 0% coinsurance | 0% coinsurance | No deductible. Limited to 1 exam/year. Please contact the Trust Fund office. |
| | Children's glasses | Fund will pay up to contracted rate and member will be | 0% coinsurance | No deductible. Limited to 1 pair of glasses or 1 contact lens purchase/year. |

| 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) | |
| | | responsible for the difference | | |
| | Children's dental check-up | 25% coinsurance of PPO rate; no deductible | 25% coinsurance of dental non-PPO fee schedule; no deductible | No annual maximum if under age 19 but $2,500 maximum if over age 19. No deductible |

## 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
- Routine Foot Care
- Weight Loss Programs (except for medically necessary nutritional counseling)
- Infertility Treatment
- Long Term Care
- Private Duty Nursing
- Dialysis
- Non-emergency care when traveling outside the U.S.

**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 (30 visits/year for vertebrae, spine, back and neck only)
- Dental Care (Adult & Dependents)
- Hearing Aid (50% every three years)
- 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.

**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.*

## 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 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** | **$350** |
| **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** | **$12,780** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $ |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Peg would pay is** | **$2,350** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **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** | **$7,380** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $350 |
| Copayments | $ |
| Coinsurance | $1,406 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Joe would pay is** | **$1,756** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| **The plan's overall deductible** | **$350** |
| **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** | **$1,880** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles (plus $100 ER deductible) | $350 plus $100 |
| Copayments | $ |
| Coinsurance | $286 |
| *What isn't covered* | |
| Limits or exclusions | $ |
| **The total Mia would pay is** | **$736** |

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