Five Rivers Carpenters District Council PPO

Coverage Period: 01/01/2021 – 12/31/2021
Coverage for: Single & Family | Plan Type: PPO

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, visit www.5RCbenefits.com or call 1-800-847-0113. 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 1-800-847-0113 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: $200 person/$400 family per calendar year. Out-of-Network: $500 person/$1,000 family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, telehealth services, your drug card costs and preventive care 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.
Are there other deductibles for specific services?	No. There are no other deductibles. Drug card deductible?	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $500 person/$1,000 family per calendar year. Out-Of-Network: $2,000 person/$3,500 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, your drug card costs, balance-billed 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. See www.wellmark.com or call 1-800-524-9242 for a list of health 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). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

For more information about limitations and exceptions, see your plan document at www.5RCbenefits.com.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% coinsurance	Contracted telehealth services are covered.
	Specialist visit	10% coinsurance	20% coinsurance	Contracted telehealth services are covered.
	Preventive care/screening/ immunization	No charge	0% coinsurance	One preventive exam, one gynecological exam, one Pap smear and one mammogram per calendar year. Well-child care is covered to age 26. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	------None------

For more information about limitations and exceptions, see your plan document at www.5RCbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com.	Tier 1	Greater of $10 or 10% (retail); $0 (mail order)	Greater of $10 or 10% (retail); $0 (mail order)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription); $100 copay maximum applies to specialty drugs purchased through the SavRx specialty pharmacy. Prior authorization and clinical management programs apply to certain medications.
	Tier 2	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	
	Tier 3	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	
	Tier 4	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	Greater of $20 or 20% (retail); greater of $40 or 20% (mail order)	
	Specialty drugs	Greater of $10 or 10% (retail); $0 (mail order)	Greater of $10 or 10% (retail); $0 (mail order)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	10% coinsurance	20% coinsurance	For emergency medical conditions treated out-of-network, you may be balance billed.
	Emergency medical transportation	10% coinsurance	10% coinsurance	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service.
	Urgent care	10% coinsurance	20% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	Contracted telehealth services are covered.
	Inpatient services	10% coinsurance	20% coinsurance	------None------
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Except for complications of pregnancy and mandated preventive services, all maternity services for dependent children are not covered. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	------None------

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Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	------None------
	Rehabilitation services	10% coinsurance	20% coinsurance	------None------
	Habilitation services	10% coinsurance	20% coinsurance	------None------
	Skilled nursing care	10% coinsurance	20% coinsurance	------None------
	Durable medical equipment	10% coinsurance	20% coinsurance	Foot orthotics are covered up to $300 maximum per calendar year. Penile prosthesis is not covered.
	Hospice services	10% coinsurance	20% coinsurance	------None------
If your child needs dental or eye care	Children's eye exam	$0	$0	(Birth to age 18) one routine vision exam with no calendar year benefit maximum.
	Children's glasses	$0	$0	(Birth to age 18) one pair of eye glass lenses is covered with no calendar year benefit maximum. Frames are subject to $200 per two year limit.
	Children's dental check-up	$0	$0	(Birth to age 18) routine periodic examinations limited to two exams per calendar year with no calendar year benefit maximum.

For more information about limitations and exceptions, see your plan document at www.5RCbenefits.com.

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.)	
• Acupuncture	• Glasses
• Bariatric surgery	• Hearing aids
• Cosmetic surgery	• Infertility treatment
• Custodial care - in home or facility	• Long-term care
• Dental care - Adult	• Routine eye care - Adult
• Dental check-up	• Routine foot care
• Eye exam	• Weight loss programs

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

- Chiropractic care - Out-of-Network, $500 per calendar year
- Extended home skilled nursing
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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, you can contact: Five Rivers Carpenters District Council at 1-800-847-0113, Iowa Insurance Division at 515-281-5705, or 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.

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

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

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 may 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	$200
PCP coinsurance	10%
Hospital(facility) coinsurance	10%

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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$510
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$710

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Other coinsurance	10%

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$250
What isn't covered	
Limits or exclusions	$800
The total Joe would pay is	$1,250

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Emergency room coinsurance	10%

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$500