 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 <https://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 <u>deductible</u> ?	In- <u>Network</u> : \$200 person/\$400 family per calendar year. Out-of- <u>Network</u> : \$500 person/\$1,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> 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> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, telehealth services, your drug card costs and <u>preventive care</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.
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductibles</u> .	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Health In- <u>Network</u> : \$500 person/\$1,000 family per calendar year. Health Out-Of- <u>Network</u> : \$2,000 person/\$3,500 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, your drug card costs, <u>balance-billed 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 <u>network provider</u> ?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of health <u>network providers</u> .	This plan uses a <u>provider 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>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</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 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	20% <u>coinsurance</u>	Contracted telehealth services are covered.
	<u>Specialist</u> visit	10% coinsurance	20% coinsurance	Contracted telehealth services are covered.
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u>	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the <u>network</u> rate for certain charges from <u>out-of-network</u> providers when received at a <u>network</u> facility or during an emergency medical condition. For more information, contact the Benefit Office.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> 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. Specialty Drugs limited to 30-day supply.
	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 \$20 or 20% (retail)	Greater of \$20 or 20% (retail)	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	<u>Physician/surgeon fees</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	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 as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Pursuant to the federal rules of the No Surprises Act, in some circumstances, you may only be responsible for the network rate for certain charges from out-of-network providers when received at a network facility or during an emergency medical condition. For more information, contact the Benefit Office.
	<u>Physician/surgeon fees</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Contracted telehealth services are covered.
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Except for mandated <u>preventive services</u> , 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% <u>coinsurance</u>	20% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.

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
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Foot orthotics are covered up to \$300 maximum per calendar year. Penile prosthesis is not covered.
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

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

- Applied Behavior Analysis Therapy
- 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 Health and Welfare Fund at 1-800-847-0113.

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*)

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*)

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
What isn't covered	
Limits or exclusions	\$70
The total Peg would pay is	\$770

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,600

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$10
The total Mia would pay is	\$510

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