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?	$300 per person and $600 per family per calendar year for network providers. $900 per person and $1,800 per family per calendar year for out-of-network providers.	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, 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. 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.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical: $3,000 per person and $6,000 per family per calendar year for network providers. $9,000 per person and $18,000 per family per calendar year for out-of-network providers. Drug Card: $6,100 per person and $12,200 per family per calendar year. The in-network health and drug card out-of-pocket limit amounts accumulate separately.	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-billing 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.

Important Questions	Answers	Why This Matters:
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 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.
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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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	30% coinsurance	Contracted telehealth services are covered.
	Specialist visit	20% coinsurance	30% coinsurance	Contracted telehealth services are covered. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ Immunization	No charge	NA	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 care. Ask your provider if the services needed are preventive care. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	------None------

[* For more information about limitations and exceptions, see the plan at www.5RCbenefits.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.savrx.com	Tier 1 = Generic	Retail: 10% coinsurance for a 30 day fill ($10 minimum copayment) Mail Order: $0 copayment for a 90 day fill	NA	Covers up to a 30-day supply (retail prescription); 90-day supply (mail-order prescription); $100 copayment 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 = Brand	Retail: 20% coinsurance per 30 days ($20 minimum copayment) Mail Order: 20% coinsurance per 90 days 10% ($40 minimum copayment)	NA	
	Tier 3 = Brand with Generic	Retail: 20% coinsurance per 30 days ($20 minimum copayment + difference in cost) Mail Order: 20% coinsurance per 90 days 10% ($40 minimum copayment + difference in cost)	NA	
	Specialty Drugs	Generic: 20% coinsurance ($20 minimum, $100 maximum) Brand: 20% coinsurance ($20 minimum, $100 maximum) Brand with Generic: 20% coinsurance ($20 minimum+ difference in cost)	NA	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	------None------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For emergency medical conditions treated at an out-of-network provider, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	20% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network provider 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.
	Urgent care	20% coinsurance	30% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	30% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Contracted telehealth services are covered.
	Inpatient services	20% coinsurance	30% coinsurance	------None------

[* For more information about limitations and exceptions, see the plan at www.5RCbenefits.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Except for mandated preventive care 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 care services.
	Childbirth/delivery professional services	20% coinsurance	30% 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	20% coinsurance	30% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	------None------
	Rehabilitation services	20% coinsurance	30% coinsurance	------None------
	Habilitation services	20% coinsurance	30% coinsurance	------None------
	Skilled nursing care	20% coinsurance	30% coinsurance	------None------
	Durable medical equipment	20% coinsurance	30% coinsurance	------None------
	Hospice services	20% coinsurance	30% coinsurance	Foot orthotics are covered up to the $300 maximum per calendar year. Penile prosthesis is not covered.
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-ups
- Eye exams
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

[* For more information about limitations and exceptions, see the plan at www.5RCbenefits.com.]

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 US	• 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. 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 on how 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 Five Rivers Carpenters District Council Health and Welfare Fund at 1-800-847-0113 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.
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.

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

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.

[* For more information about limitations and exceptions, see the plan at www.5RCbenefits.com.]

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	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$12,700

In this example, Peg would pay:

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

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$5,600

In this example, Joe would pay:

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

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$810

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