Plasterers and Cabinet Makers Health Fund

Coverage Period: April 1, 2021 – March 31, 2022

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Participants and Dependents | **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, contact the Plan Administrator, Wilson-McShane Corporation at 952-854-0795. 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. dol.gov/ebsa/healthreform.com or call 1-800-535-6373 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** individual/**$400** family	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.**	This plan covers some items and services even if you haven't yet me the **deductible** amount. For example, preventive care benefits are not subject to the **deductible**. See a list of preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**Yes.** $50 individual/$150 family dental expense **deductible**. There are no other specific **deductibles**.	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. **This deductible only applies to Plasterers Dental Coverage.** Cabinet Makers and Industrial Carpenters are **only** eligible for Diagnostic and Preventive Services (Coverage A) under the Plan's Dental Benefits.
What is the out-of-pocket limit for this plan?	**Yes. $3,000** individual/**$6,000** family	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 **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?	Deductibles, certain co-payments, balance-billed charges, health care this plan does not cover and out-of-pocket costs for dental, vision, and prescription drug benefits.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Do you need a referral to see a specialist?	No.	You can see a **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
		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% co-insurance	40% co-insurance	Includes telehealth services as long as provided by a medical provider who offers such services through an established medical office or clinic.
	Specialist visit	20% co-insurance	40% co-insurance	----------None----------
	Preventive care/screening/ immunization	0% co-insurance	40% co-insurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	----------None----------
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	----------None----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	20% co-insurance ($5 minimum)	20% co-insurance ($5 minimum)	34-day or 100-unit supply limitation, whichever is greater for retail prescriptions; 90-day or 100-unit supply limitation, whichever is greater, for mail order prescriptions.
	Preferred brand drugs	30% co-insurance ($10 minimum)	30% co-insurance ($10 minimum)	34-day or 100-unit supply limitation, whichever is greater for retail prescriptions; 90-day or 100-unit supply limitation, whichever is greater, for mail order prescriptions.
	Non-preferred brand drugs	30% co-insurance ($5 minimum)	30% co-insurance ($5 minimum)	34-day or 100-unit supply limitation, whichever is greater for retail prescriptions; 90-day or 100-unit supply limitation, whichever is greater, for mail order prescriptions.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	----------None----------
	Physician/surgeon fees	20% co-insurance	40% co-insurance	----------None----------
If you need immediate medical attention	Emergency room care	$100 copayment; 20% co-insurance	$100 copayment; 20% co-insurance	$100 copayment is waived if you are admitted to the hospital from the emergency room.
	Emergency medical transportation	20% co-insurance	40% co-insurance	Transportation not necessary for basic or advanced life support or for convenience is excluded.
	Urgent care	20% co-insurance	40% co-insurance	The Plan offers and covers the Doctor on Demand Service at 100%. You can access the service at: DoctorOnDemand.com/bluecrossmn

If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	No coverage	Limited to hospital's average daily semi-private rate.
	Physician/surgeon fees	20% co-insurance	No coverage	----------None----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	----------None----------
	Inpatient services	20% co-insurance	No coverage	----------None----------
If you are pregnant	Office visits	Prenatal care 0% co-insurance Postnatal care 20% co-insurance	Prenatal care 0% co-insurance Postnatal care 40% co-insurance	Charges for surrogate pregnancy or adoption are excluded.
	Childbirth/delivery professional services	20% co-insurance	No coverage	Charges for surrogate pregnancy or adoptions are excluded. For out-of-network, if the delivery is a medical emergency, delivery and inpatient will be covered under the emergency room services benefit as long as the condition continues to meet the Plan's definition of Emergency Medical Condition.
	Childbirth/delivery facility services	20% co-insurance	No coverage	
If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Limit of 180 visits per calendar year.
	Rehabilitation services	20% co-insurance	40% co-insurance	Charges for educational, vocational rehabilitation, developmental delay, self-care, health clubs, learning disability, and recreational therapy are excluded.
	Skilled nursing care	20% co-insurance	40% co-insurance	Limit of 120 days confinement per calendar year.
	Durable medical equipment	20% co-insurance	40% co-insurance	Maximum benefit for wigs is $350 per calendar year. Charges for personal and convenience items, appliances, exercise machines, duplicates, and foot support services are excluded.
	Hospice services	20% co-insurance	40% co-insurance	----------None----------

If your child needs dental or eye care	Children's eye exam	20% co-insurance	40% co-insurance	Payment of 100% of cost for children under age 6.
	Children's glasses	Any costs above the provided benefit of up to $200 per 2 consecutive years for frames, lenses and contact lenses.	Any costs above the provided benefit of up to $200 per 2 consecutive years for frames, lenses and contact lenses.	----------None----------
	Children's dental check-up	0% co-insurance	10% co-insurance	----------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.
- Hearing aids
- Long-term care.
- Non-emergency care when traveling outside the U.S.
- Private duty nursing.
- 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.)

- Chiropractic care.
- Dental care.
- Infertility treatment.
- Routine eye care.

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-44-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: Plan Administrator, Wilson-McShane Corporation at 952-854-0795. You may also contact the United States Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 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 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, 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**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$5
Coinsurance	$2,470
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,735**

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** **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	**$6,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$660
Coinsurance	$185
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,065**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) insurance** **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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