
 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 Fund Office at 1-816-756-3313. 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 1-816-756-3313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$320 per person/\$640 per family	Generally, you must pay all of 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. Flu shots, PPO adult vaccines, well child benefits, <u>prescription drugs</u> , <u>hospice services</u> , and hearing aids 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.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	PPO: \$2,890 per person; Non-PPO: \$5,780 per person	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Deductible(s)</u> , <u>prescription drug coinsurance</u> , <u>premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not 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.bluekc.com for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's 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 <u>provider's</u> 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		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO 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	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist visit</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Chiropractic treatment limited to 5 visits per calendar year.
	<u>Preventive care/screening/immunization</u>	No charge for a physical exam (up to \$350 per year) and well child benefits (up to \$500; no <u>deductible</u>). 15% <u>coinsurance</u> for other services.	No charge for a physical exam (up to \$350 per year) and well child benefits (up to \$500; no <u>deductible</u>). 30% <u>coinsurance</u> for other services.	Flu shots and adult vaccines covered at 100% (no <u>deductible</u>) if obtained from a PPO <u>provider</u> . Flu shots covered at 100% (no <u>deductible</u>) and adult vaccines covered up to \$100 (no <u>deductible</u>) if obtained from a Non-PPO <u>provider</u> . Vaccines for foreign travel are not covered.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	X-rays for chiropractic treatment are limited to the number of x-rays ordered for no more than 5 chiropractic treatment visits per calendar year.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to review for medical necessity.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com .	Generic drugs	20% <u>coinsurance</u> retail and mail order. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> (retail only). <u>Deductible</u> does not apply.	Supply: up to the greater of 34-day supply or 100-unit dose retail and 90-day supply mail order.
	Brand Name drugs	20% <u>coinsurance</u> retail and mail order. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> (retail only). <u>Deductible</u> does not apply.	90-day supply for maintenance medications can be filled at retail pharmacies through CVS's 90-day program.
	<u>Specialty drugs</u>	20% <u>coinsurance</u> retail and mail order. <u>Deductible</u> does not apply.	20% <u>coinsurance</u> (retail only). <u>Deductible</u> does not apply.	Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> . <u>Specialty drugs</u> filled by CVS specialty pharmacy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	The fee for an assistant surgeon who is a physician is limited to 20% and a physician assistant is limited to 10% of the PPO allowance or the reasonable and customary charge for the surgical procedure.
If you need immediate medical attention	<u>Emergency room care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u> , except 15% <u>coinsurance for air ambulance services</u>	None
	<u>Urgent care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Private-room rates are covered if required due to the patient's condition. If the hospital only has private rooms, the charge for the most common private-room rate for that hospital will be covered.
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u>	The fee for an assistant surgeon who is a physician is limited to 20% and a physician assistant is limited to 10% of the PPO allowance or the reasonable and customary charge for the surgical procedure.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you are pregnant	Office visits	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery professional services	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Childbirth/delivery facility services	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Non-PPO Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Adult restorative speech therapy limited to 20 visits per calendar year.
	<u>Habilitation services</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	20 visits per calendar year maximum for speech therapy for childhood developmental speech delays.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u>	Limit of one device per person per limb in any three consecutive calendar years.
	<u>Hospice services</u>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Limited to 6 months per person in a 3-calendar-year period.
If your child needs dental or eye care	Children's eye exam	Not covered		You must pay 100% of this service, even from a PPO <u>provider</u> .
	Children's glasses	Not covered		You must pay 100% of this service, even from a PPO <u>provider</u> .
	Children's dental check-up	Not covered		You must pay 100% of this service, even from a PPO <u>provider</u> .

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 (except for pain relief if other methods are unsuccessful)
- Bariatric surgery
- Cosmetic surgery (except for injury or for reconstructive surgery following a mastectomy as required by the Women's Health and Cancer Rights Act of 1998, "WHCRA")
- Dental care (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs (except for preventive care, some prescriptions covered if morbid obesity is diagnosed)

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

- Chiropractic care (limited to 5 visits per calendar year)
- Hearing aids (no charge and deductible does not apply up to \$1,000 per ear, every 5 years)
- Private-duty nursing (for home health 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 that agency is: the 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: 1-816-756-3313. You may also contact the 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

[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](#).

Language Access Services:

Para obtener asistencia en Español, llame al 1-816-756-3313.

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 PPO pre-natal care and a hospital delivery)

■ <u>The plan's overall deductible</u>	\$320
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	15%
■ <u>Other coinsurance</u>	15%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$320
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,840
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,220

Managing Joe's type 2 Diabetes

(a year of routine PPO care of a well-controlled condition)

■ <u>The plan's overall deductible</u>	\$320
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	15%
■ <u>Other coinsurance</u>	15%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$320
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$850
<i>What isn't covered</i>	
Limits or exclusions	\$700
The total Joe would pay is	\$1,870

Mia's Simple Fracture

(PPO emergency room visit and follow up care)

■ <u>The plan's overall deductible</u>	\$320
■ <u>Specialist coinsurance</u>	15%
■ <u>Hospital (facility) coinsurance</u>	15%
■ <u>Other coinsurance</u>	15%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$320
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$690