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.dol.gov/ebsa/healthreform or call 1-816-756-3313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$320** per person/**$640** per family	Generally, you must pay all of 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. Flu shots, adult vaccines and immunizations, child vaccines, well child benefits, prescription drugs, hospice services, and hearing aids 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?	Yes. Dental: **$25** per person. 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.
What is the out-of-pocket limit for this plan?	PPO: **$2,890** per person; Non-PPO: **$5,780** per person Certain Non-PPO claims are treated as PPO claims as required by No Surprises Act.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Deductible(s), prescription drug coinsurance, premiums, balance billing charges, and health care this plan does not 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.bluekc.com for a list of network providers. Out-of-network providers may be treated as network providers as required by No Surprises Act.	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
		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% coinsurance	30% coinsurance	None
	Specialist visit	15% coinsurance	30% coinsurance	Chiropractic treatment limited to 5 visits per calendar year.
	Preventive care/screening/ immunization	No charge for a physical exam (up to $350 per year) and well child benefits (up to $500; no deductible). 15% coinsurance for other services.	No charge for a physical exam (up to $350 per year) and well child benefits (up to $500; no deductible). 30% coinsurance for other services.	Flu shots, adult vaccines and immunizations, and child vaccines covered at 100% (no deductible or coinsurance).Vaccines for foreign travel are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	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% coinsurance	30% coinsurance	Subject to review for medical necessity.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com or by calling Express Scripts Customer Service at (877) 724-7550.	Generic drugs	20% coinsurance retail and mail order. Deductible does not apply.	20% coinsurance (retail only). Deductible does not apply.	Supply: up to 30-day supply retail and 90-day supply mail order. 90-day supply for maintenance medications can be filled at retail pharmacies through ESI's 90-day program. Your cost sharing does not count toward the out-of-pocket limit. Specialty drugs filled by Accredo Specialty Pharmacy.
	Brand Name drugs	20% coinsurance retail and mail order. Deductible does not apply.	20% coinsurance (retail only). Deductible does not apply.	
	Specialty drugs	20% coinsurance retail and mail order. Deductible does not apply.	20% coinsurance (retail only). Deductible does not apply.	

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% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
	Physician/surgeon fees	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	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	Emergency room care	15% coinsurance	15% coinsurance	None
	Emergency medical transportation	15% coinsurance	30% coinsurance, except 15% coinsurance for air ambulance services	None
	Urgent care	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	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% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	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.

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 mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
	Inpatient services	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
If you are pregnant	Office visits	15% coinsurance	30% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
	Childbirth/delivery facility services	15% coinsurance	30% coinsurance unless otherwise required by No Surprises Act.	None
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	None
	Rehabilitation services	15% coinsurance	30% coinsurance	Adult restorative speech therapy limited to 20 visits per calendar year.
	Habilitation services	15% coinsurance	30% coinsurance	20 visits per calendar year maximum for speech therapy for childhood developmental speech delays.
	Skilled nursing care	15% coinsurance	30% coinsurance	None
	Durable medical equipment	15% coinsurance	30% coinsurance	Limit of one device per person per limb in any three consecutive calendar years.
	Hospice services	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Limited to 6 months per person in a 3-calendar-year period.

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 your child needs dental or eye care	Children's eye exam	No charge	No charge	Limit of one exam per calendar year.
	Children's glasses	No charge	No charge	Limit of one pair of glasses or contacts per calendar year.
	Children's dental check-up	20% coinsurance		$25 per person deductible applies; limit two dental check-ups per person per calendar year. $1,750 maximum per person per calendar year.

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")
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except for preventive care)

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)
- Dental care (Adult) ($1,750 maximum per person per calendar year)
- Hearing aids (no charge and deductible does not apply up to $1,500 per ear, every 3 years; must be obtained through TruHearing)
- Private-duty nursing (for home health care)
- Routine eye care (Adult) (No charge up to $250 maximum per person during a two-consecutive calendar-year period)

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)

The plan's overall deductible	$320
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$320
Copayments	$0
Coinsurance	$1,840
What isn't covered	
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)

The plan's overall deductible	$320
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$320
Copayments	$0
Coinsurance	$850
What isn't covered	
Limits or exclusions	$700
The total Joe would pay is	**$1,870**

Mia's Simple Fracture
(PPO emergency room visit and follow up care)

The plan's overall deductible	$320
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$320
Copayments	$0
Coinsurance	$370
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$690**

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