



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](http://www.dol.gov/ebsa/healthreform) or call 1-816-756-3313 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Flu shots, adult vaccines and immunizations, child 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.
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	PPO: \$2,890 per person; Non-PPO: \$5,780 per person Certain Non-PPO <u>claims</u> are treated as PPO <u>claims</u> as required by No Surprises Act.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<u>What is not included in the out-of-pocket limit?</u>	Deductible(s), <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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See <a href="http://www.bluekc.com">www.bluekc.com</a> for a list of <u>network providers</u> . <u>Out-of-network providers</u> may be treated as <u>network providers</u> as required by No Surprises Act.	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 charge</u> 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> .
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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
	Specialist visit	15% <u>coinsurance</u>	30% <u>coinsurance</u>	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 <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, adult vaccines and immunizations, and child vaccines covered at 100% (no <u>deductible</u> or <u>coinsurance</u> ). Vaccines for foreign travel are not covered.
If you have a test	Diagnostic test (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 <u>medical necessity</u> .

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or by calling Express Scripts Customer Service at (877) 724-7550.	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 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.
	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.	Your <u>cost sharing</u> does not count toward the <u>out-of-pocket limit</u> .
	Specialty 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.	<u>Specialty drugs</u> filled by Accredo Specialty Pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u> 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.
<b>If you need immediate medical attention</b>	<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</u> for air ambulance services	None
	<u>Urgent care</u>	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	30% <u>coinsurance</u> 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% <u>coinsurance</u>	30% <u>coinsurance</u> 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% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
	Inpatient services	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
If you are pregnant	Office visits	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
	Childbirth/delivery professional services	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
	Childbirth/delivery facility services	15% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act.	None
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.

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	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)

### 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 \$1,500 per ear, every 3 years; must be obtained through TruHearing)
- 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](http://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](http://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](http://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 <u>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**

In this example, Peg would pay:

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

### Managing Joe's Type 2 Diabetes

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

■ The <u>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**

In this example, Joe would pay:

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

### Mia's Simple Fracture

(PPO emergency room visit and follow up care)

■ The <u>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**

In this example, Mia would pay:

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

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