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, call (833) 479-9429. 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 https://www.healthcare.gov/sbc-glossary/ or call (833) 479-9429 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/individual or $800/family (Limited to 2 individuals per family per year).	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. Routine Physical, Preventive Care and Prescription Drug Benefits 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000/ individual	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?	Deductibles, prescriptions, charges in excess of plan maximums, premiums, 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.
Will you pay less if you use a network provider?	Yes. See www.mybluekc.com or call (800) 810-BLUE 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	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	Teleheath Amwell Program – no copayment, deductible or coinsurance. Telehealth Amwell is an In-Network Benefit only – no coverage for any telemedicine program other than Telehealth Amwell.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization		Not covered	In-Network providers not subject to the deductible. Routine Physical Exam for Employee and Spouse only (including but not limited to: pap smear, mammogram, gynecological exam and prostrate exam). Colonoscopy limited to 1 every 10 years for members 50 and older. No other preventive services are covered for adults, including vaccines. Pediatric preventive care from In-Network providers covered at 100% with no copayment, deductible or coinsurance. Covered services include but are not limited to: routine physical exams as recommended by the American Academy of Pediatrics, newborn hearing screenings and appropriate follow-up and childhood immunizations as recommended by the Center for Disease Control. You may have to pay for pediatric services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			

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 For more information about **prescription drug coverage** contact your Prescription Drug Manager at the phone number listed on your prescription ID card.	Generic drugs	Retail – 20% coinsurance Mail Order – 13% coinsurance	Retail – 20% coinsurance	Prescription Drug Charges do not apply to the deductible or out-of-pocket limit. Retail is up to 30-day supply. Mail Order is 90-day supply. Out-of-Network – Member pays 100% then submits for reimbursement. No coverage for Medicare Eligible Retirees.
	Formulary brand drugs			
	Non-formulary brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance After $70 copayment	40% coinsurance After $70 copayment	Emergency Room services are subject to the Calendar Year deductible first, then the $70 copayment applies and then the member's coinsurance. Copayment waived if you are admitted to the hospital.
	Emergency medical transportation	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	----------none----------
	Urgent care			Teleheath Amwell Program – no copayment, deductible or coinsurance. Telehealth Amwell is an In-Network Benefit only – no coverage for any telemedicine program other than Telehealth Amwell.
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	Benefits based on hospital's average semi-private room rate. After 23 observation hours, a confinement will be considered an inpatient confinement.
	Physician/surgeon fees			----------none----------

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 mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	----------none----------
	Inpatient services			
If you are pregnant	Office visits	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery.
If you need help recovering or have other special health needs	Home health care	Tier 1 - 10% coinsurance Tier 2- 15% coinsurance	40% coinsurance	----------none----------
	Rehabilitation services			
	Habilitation services			Limited speech therapy available. Call the Fund Office for more information.
	Skilled nursing care			Must be within 14 days of a Hospital confinement of at least 3 days. A treatment plan from attending Physician is required.
	Durable medical equipment			Prior approval from Fund Office is required when purchasing equipment but not when renting equipment.
	Hospice services			Limited to 6 months every 3 years.
If your child needs dental or eye care	Children's eye exam	No charge up to $50		Limited to once every calendar year.
	Children's glasses	Frames – No charge up to $90. Lenses – No charge up to: Single: $60 Contacts: $100 Bifocal: $100 Trifocal:$125 Lenticular: $130		Limited to once every calendar year for dependents under age 19.
	Children's dental check-up	20%		Limited to $2,000 calendar year maximum. Maximum includes check-ups and other dental services.

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 (unless Medically Necessary) • Infertility treatment	• Long-term care (unless Medicare approved and then restrictions apply) • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care (unless Medically Necessary) • Weight loss programs (unless Medically Necessary)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care (Employee & Spouse only) • Cosmetic surgery (restrictions apply)	• Dental care (adult) • Hearing aids (Actives only – restrictions apply)	• Routine eye care (adult)

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: Department of Labor's Employee Benefits Security Administration at (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 (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: the Fund Office at (833) 479-9429 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (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.

Language Access Services:
Para obtener asistencia en Español, llame al (833) 479-9429.

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** **$400**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,700**

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

- **The plan's overall deductible** **$400**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,600**

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

- **The plan's overall deductible** **$400**
- **Specialist coinsurance** **10%**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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

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