



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 <u>deductible</u>?	\$400/individual or \$800/family (Limited to 2 individuals per family per year).	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. Routine Physical, Preventive Care and <u>Prescription Drug</u> Benefits 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>?	\$3,000/ individual	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>Deductibles</u> , <u>prescriptions</u> , charges in excess of <u>plan</u> maximums, <u>premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't 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.mybluekc.com or call (800) 810-BLUE 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 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> .



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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	BlueKC Virtual Care – no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . BlueKC Virtual Care is an <u>in-network</u> Benefit - coverage for other <u>in-network</u> and <u>out-of-network</u> virtual care programs are subject to the same <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> as an in-person visit.
	<u>Specialist</u> visit		-----none-----	
	<u>Preventive care/screening/immunization</u>		Not covered	<u>In-Network providers</u> not subject to the <u>deductible</u> . Routine Physical Exam for Employee, Spouse and Dependent Children over age 21 and under age 26 (including but not limited to: pap smear, mammogram, gynecological exam and prostate exam). Colonoscopy limited to 1 every 10 years for members 50 and older. No other <u>preventive services</u> are covered for adults, including vaccines, with the exception of the Influenza, Shingles and COVID-19 vaccines. <u>Pediatric preventive care</u> (through age 21) from <u>In-Network providers</u> covered at 100% with no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . 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 <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.

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 have a test	<u>Diagnostic test</u> (x-ray, blood work)	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	No deductible, <u>copayment</u> or <u>coinsurance</u> on COVID-19 testing at any <u>provider</u> (in-network or out-of-network).
	<u>Imaging</u> (CT/PET scans, MRIs)			-----none-----
If you need <u>drugs</u> to treat your illness or condition For more information about <u>prescription drug coverage</u> contact your Prescription Drug Manager at the phone number listed on your prescription ID card.	<u>Generic drugs</u>	Retail – 20% <u>coinsurance</u> Mail Order – 13% <u>coinsurance</u>	Retail – 20% <u>coinsurance</u>	<u>Prescription Drug Charges</u> do not apply to the deductible or <u>out-of-pocket limit</u> . Retail is up to 30-day supply. Mail Order is 90-day supply. <u>Out-of-Network</u> – Member pays 100% then submits for reimbursement. No coverage for Medicare Eligible Retirees.
	<u>Formulary brand drugs</u>			
	<u>Non-formulary brand drugs</u>			
	<u>Specialty drugs</u>			
If you have outpatient surgery	<u>Facility fee</u> (e.g., ambulatory surgery center)	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Physician/surgeon fees</u>			
If you need immediate medical attention	<u>Emergency room care</u>	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u> After \$70 <u>copayment</u>	40% <u>coinsurance</u> After \$70 <u>copayment</u>	<u>Emergency Room services</u> are subject to the Calendar Year <u>deductible</u> first, then the \$70 <u>copayment</u> applies and then the member's <u>coinsurance</u> . <u>Copayment</u> waived if you are admitted to the hospital.
	<u>Emergency medical transportation</u>			-----none-----
	<u>Urgent care</u>	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>BlueKC Virtual Care</u> – no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . <u>BlueKC Virtual Care</u> is an <u>In-Network Benefit</u> - coverage for other <u>in-network</u> and <u>out-of-network</u> virtual care programs are subject to the same <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> as an in-person visit.

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 have a hospital stay	Facility fee (e.g., hospital room)	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits based on hospital's average semi-private room rate. After 23 observation hours, a confinement will be considered an <u>inpatient confinement</u> .
	Physician/surgeon fees			-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	BlueKC Virtual Care – no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . Blue KC Virtual Care is an <u>In-Network</u> Benefit - coverage for other <u>in-network</u> and <u>out-of-network</u> virtual care programs are subject to the same <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> as an in-person visit.
	Inpatient services			-----none-----
If you are pregnant	Office visits	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> or a <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). <u>Inpatient stay</u> 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.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	<u>Home health care</u>	Tier 1 - 10% <u>coinsurance</u> Tier 2- 15% <u>coinsurance</u>	40% <u>coinsurance</u>	-----none-----
	<u>Rehabilitation services</u>			
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>			
	<u>Durable medical equipment</u>			

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)	
	<u>Hospice services</u>			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 or Progressive: \$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 up to two routine preventive visits per calendar year 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.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery (unless Medically Necessary) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care (unless Medicare approved and then restrictions apply) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Chiropractic care (Employee & Spouse only) • Cosmetic surgery (restrictions apply) 	<ul style="list-style-type: none"> • Dental care (adult) • Hearing aids (Actives only – restrictions apply) 	<ul style="list-style-type: none"> • 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**

[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 (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)

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

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%**

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- Hospital (facility) coinsurance **10%**
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- 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*)

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*)

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	\$12,700
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Total Example Cost	\$5,600
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Total Example Cost	\$2,800
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,660

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$70
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$670

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