




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 1-816-777-2668. 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 1-816-777-2668 or 1-833-479-9428 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network*: \$300 Person/\$600 Family Out-of-network: \$500 Person/ \$1,000 Family <i>Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.</i>	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 deductible?	Yes. Routine Care, <u>Preventive</u> , Flu Shot, BlueKC Virtual 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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$7,500 per Family <i>Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.</i>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Copayments</u> for <u>prescription drugs</u> , acupuncture, chiropractic benefits, well child benefits, <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 network provider?	Yes*. See www.mybluekc.com or call (800) 810-2583 for a list of <u>network providers</u> . <i>*Out-of-network providers may be treated as In-network providers as required by No Surprises Act.</i>	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
		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</u> office or clinic	Primary care visit to treat an injury or illness	10% <u>coinsurance</u>	30% <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 only. Coverage for other In-Network and Out-of-Network virtual care programs are subject to the same <u>copayment</u> , <u>deductible</u> and <u>coinsurance</u> as an in-person visit.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u>	<u>In-network</u> – No <u>Deductible</u> . You may have to pay for 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. For specific benefits and limitations, see the <u>plan</u> document at Section Four, subsection O.*
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Some services may require <u>preauthorization</u>
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Subject to review for <u>medical necessity</u> .

*For more information about limitations and exceptions, see summary plan description (SPD).

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 More information about <u>prescription drug coverage</u> is available at www.savrx.com or by calling Sav-Rx Prescription Services at (800) 228-3108	Generic <u>drugs</u>	Retail – Lesser of \$10 or 100% of <u>drug</u> cost (up to 34-day supply); Lesser of \$20 or 100% of <u>drug</u> cost (up to 90-day supply); Mail Order – Lesser of \$20 or 100% of <u>drug</u> cost (up to 90-day supply)	Retail – Lesser of \$10 or 100% of <u>drug</u> cost (up to 34-day supply); Lesser of \$20 or 100% of <u>drug</u> cost (up to 90-day supply); Mail Order – Lesser of \$20 or 100% of <u>drug</u> cost (up to 90-day supply)	No <u>deductible</u> on Prescription Benefits. <u>Copayment</u> does not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . If a participant chooses to utilize a brand <u>drug</u> when a generic equivalent is available, such participant will be required to obtain a letter of necessity from their physician in order to pay the standard brand <u>copayment</u> . Without such letter of necessity, the participant will be required to pay the Non-preferred <u>drug copayment</u> plus the difference in cost between the brand <u>drug</u> and generic.
	Preferred brand <u>drugs</u>	Retail – Greater of \$25 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$50 or 20% of <u>drug</u> cost (up to 90-day supply)	Retail – Greater of \$25 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$50 or 20% of <u>drug</u> cost (up to 90-day supply)	
	Non-preferred brand <u>drugs</u>	Retail – Greater of \$40 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$80 or 20% of <u>drug</u> cost (up to 90-day supply)	Retail – Greater of \$40 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$80 or 20% of <u>drug</u> cost (up to 90-day supply)	
	<u>Specialty drugs</u>	Retail – Greater of \$40 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$80 or 20% of <u>drug</u> cost (up to 90-day supply)	Retail – Greater of \$40 or 25% of <u>drug</u> cost (up to 34-day supply); Mail Order – Greater of \$80 or 20% of <u>drug</u> cost (up to 90-day supply)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	-----none-----
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	Some services may require <u>preauthorization</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)	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$100 <u>copayment</u>	30% <u>coinsurance</u> after \$100 <u>copayment</u> unless otherwise required by No Surprises Act	\$100 <u>copayment</u> waived if Covered Person admitted to hospital.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	-----none-----
	<u>Urgent care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	BlueKC Virtual Care - no <u>copayment</u> , <u>deductible</u> or <u>coinsurance</u> . BlueKC Virtual Care is an <u>In-network</u> benefit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	Semi-private room only.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	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 only. Coverage for other In-Network and Out-of-Network virtual care programs are subject to the same <u>copayment</u> , <u>deductible</u> and <u>coinsurance</u> as an in-person visit. Service or treatment must be provided by a Legally Qualified Substance Use Professional. Treatments for behavior disorders are not covered.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	

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 are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	Cost sharing 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 the SBC (i.e. ultrasound). Pregnancy of a dependent child not covered.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u> unless otherwise required by No Surprises Act	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Home Health Care</u> covered only as allowed under <u>Hospice Benefit</u> .
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Treating Physician must submit a plan of treatment to the Fund Office for approval prior to beginning therapy.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Treating Physician must submit a plan of treatment to the Fund Office for approval prior to beginning therapy.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----none-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Must be certified as <u>medically necessary</u> by the prescribing physician. Must not be beyond the appropriate level of performance and quality required under the circumstances.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maximum Counseling Visits per Bereavement – 5 (in 6 month period) per person.

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 your child needs dental or eye care	Children's eye exam	No Charge – includes one pair of eyeglasses with basic frames, or non-disposable contact lenses, which meet the minimum specifications to allow for necessary vision correction per Calendar Year for children under 19.		Vision Benefits will be limited to a \$250 per person per Calendar Year maximum. The benefit maximum does not apply to Covered Persons under age 19 to the extent such services are necessary to meet the minimum specifications to allow for <u>medically necessary</u> vision correction.
	Children's glasses			
	Children's dental check-up	20% <u>coinsurance</u>	20% <u>coinsurance</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.)		
<ul style="list-style-type: none"> • Cosmetic surgery (unless as a result of a surgical procedure covered under the <u>Plan</u>) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs (except those covered under ACA <u>preventive care guidelines</u>)
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"> • Acupuncture • Bariatric surgery (through Blue Distinction Center) (must be <u>medically necessary</u> and <u>preauthorization</u> is required) 	<ul style="list-style-type: none"> • Chiropractic care • Dental care (adult) • Hearing aids 	<ul style="list-style-type: none"> • Private-duty nursing • 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 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 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 1-816-777-2668 or 1-833-479-9428 or 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 1-816-777-2668.

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 **\$300**
- 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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,570

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible **\$300**
- 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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$300**
- 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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$600

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