This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Plan Document from the Fund Office at 305 East 103rd Terrace, Kansas City, Missouri 64114 or by calling 1-816-943-0277.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400** per person **OR** **$100** with completion of HRA and Biometric Screening	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for Chiropractic 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.
Is there an out–of–pocket limit on my expenses?	Yes, if from a participating provider. $15,000 Individual / $30,000 Family for medical and a separate $3,000 per person for specialty drugs.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Charges for out-of-network services, and any drug copays other than those through the Sav-Rx specialty program.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit** .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.bluekc.com or call 1-816-943-0277** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan

plan doesn't cover?		document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[1]	——————none——————
	Specialist visit	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[1]	——————none——————
	Other practitioner office visit	Deductible & 20% Coinsurance for Chiropractic Treatment		Annual maximum of $500.
	Preventive care/screening/immunization	No charge		Deductible and Coinsurance apply after $250 per year.
If you have a test	Diagnostic test (x-ray, blood work)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[1]	——————none——————
	Imaging (CT/PET scans, MRIs)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[1]	——————none——————

[1] 20% coinsurance if member resides outside the PPO area.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from the Fund Office by calling 1-816-943-0277.	Generic drugs	(retail) 10% Coins, min $5 (mail) $5; $0 for certain drugs		Retail covers up to a 34-day supply or 100-unit doses, whichever is greater. Mail order covers up to 90 day supply. 50% Retail Coinsurance after Fund pays $2,000. If nonparticipating provider, must pay 100% and submit for reimbursement Additional copays may be required if selecting a brand drug when a generic is available.
	Preferred brand drugs	(retail) 20% Coins, min $15 (mail) $25; $15 for certain drugs		
	Non-preferred brand drugs	(retail) 30% Coins, min $30 (mail) $50; $30 for certain drugs		
	Specialty drugs	(Sav-Rx Specialty Program) 10% Coinsurance up to $3,000 OOP Max	(retail) up to 30% Coins, depending upon drug.	Prior authorization required. 30 day supply max. Specialty drugs at retail are subject to same copays as non-specialty.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	——————none——————
	Physician/surgeon fees	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	——————none——————
If you need immediate medical attention	Emergency room services	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	Non-Emergency: Plan will pay 50% (with limit of $75 for facility fee).
	Emergency medical transportation	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	——————none——————

[2] 20% coinsurance if member resides outside the PPO area.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Urgent care	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	Pre-authorization required for an inpatient admission.
	Physician/surgeon fee	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[2]	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance	35% Coinsurance[3]	——————none——————
	Mental/Behavioral health inpatient services	10% Coinsurance	35% Coinsurance[3]	——————none——————
	Substance use disorder outpatient services	10% Coinsurance	35% Coinsurance[3]	——————none——————
	Substance use disorder inpatient services	10% Coinsurance	35% Coinsurance[3]	——————none——————
If you are pregnant	Prenatal and postnatal care	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	Coverage for member and spouse only.
	Delivery and all inpatient services	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	Coverage for member and spouse only.

[3] 20% coinsurance if member resides outside the PPO area.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	If medically necessary and in lieu of hospitalization.
	Rehabilitation services	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	————————none————————
	Habilitation services	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	————————none————————
	Skilled nursing care	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	If medically necessary and in lieu of hospitalization.
	Durable medical equipment	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	————————none————————
	Hospice service	Deductible & 10% Coinsurance	Deductible & 35% Coinsurance[3]	————————none————————
If your child needs dental or eye care	Eye exam	No charge (Through Vision Coverage)		Vision Plan Max: $300 2-year (beginning each even year) PLUS $100 annually on safety glasses
	Glasses	No charge (Through Vision Coverage)		
	Dental check-up	No Charge for preventive or diagnostic services. 20% coinsurance otherwise. (Through Dental Coverage)	20% Coinsurance	Dental Plan Max: In Network ($1,500) / Non-Network ($1,000)

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Cosmetic surgery, except as required because of accidental injury
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine foot care
- Weight loss programs, other than Bariatric surgery

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Fund Office at 1-816-943-0277. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Fund Office at 1-816-943-0277.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,420
- **Patient pays** $1,120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$20
Coinsurance	$700
Limits or exclusions	$0
Total	**$1,120**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,700
- **Patient pays** $700

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$100
Coinsurance	$200
Limits or exclusions	$0
Total	**$700**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.