IBEW Local 124 Active & Non-Medicare Retired Eligible Employees **Coverage for: Individual + Dependents | Plan Type: PPO**

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 305 East 103rd Terrace, Kansas City, Missouri 64114 or call 1-816-943-0277. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. www.healthcare.gov/sbc-glossary or call 1-816-943-0277 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$525** per adult **OR $175** with completion of HRA and Biometric Screening (**$100** for children)	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. Mental Health, Substance Abuse, Prescription drugs, vision, preventive dental, up to **$250** for Physical Examination Expense Benefit for Member and Spouse only, and up to **$300** for Accident Expense Benefit	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?	Yes. **$100** for Chiropractic care. 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.
What is the out-of-pocket limit for this plan?	For in-network providers **$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 in a year for covered services. This limit helps you plan for health care expenses. If you have other family members in this plan, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	Charges for out-of-network services and any drug coinsurance or copayments 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**.
Will you pay less if you use a network provider?	Yes. See **www.bluekc.com or call 1-816-943-0277** for a list of in-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	10% Coinsurance	35% Coinsurance[1]	You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Mammograms and colonoscopies are subject to the deductible and coinsurance even if for screening. No charge for well-baby and well-child visits (as recommended by the U.S. Preventive Services Task Force) with a network provider for children under age 18. No deductible or coinsurance will apply for Preferred Provider (at physician office) for select Preventive Vaccinations*.
	Specialist visit	10% Coinsurance	35% Coinsurance[1]	
	Preventive care/screening	(Member & Spouse) Deductible and 10% Coinsurance applied after **$250** per year. (Dependent Children) Under age 18 - No Charge Ages 18 & over - Deductible then 10% Coinsurance	(Member & Spouse) Deductible and 35% Coinsurance[1] applied after **$250** per year. (Dependent Children) Deductible then 35% Coinsurance	
	Immunizations	10% Coinsurance	35% Coinsurance[1]	COVID-19 Vaccines for ages 6 months and older covered at no charge.
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	35% Coinsurance[1]	Prior authorization may be required*.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is from the Fund Office by calling **1-816-943-0277.**	Generic drugs	Deductible does not apply. (Retail) Greater of 10% coinsurance or $5/prescription (Mail) $5/prescription; $0/prescription 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 the Plan pays $2,000/person for prescription drugs. Additional copayments may be required if selecting a brand drug when a generic is available. Prior authorization may be required*.
	Preferred brand drugs	Deductible does not apply. (Retail) Greater of 20% coinsurance or $15/prescription (Mail) $25/prescription; $15/prescription for certain drugs		
	Non-preferred brand drugs	Deductible does not apply. (Retail) Greater of 30% coinsurance or		

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)	
		$30/prescription (Mail) $50/prescription; $30/prescription for certain drugs		Therapeutic quantity limits are placed on certain medications.
	Specialty drugs	(Sav-Rx Specialty Program) 10% Coinsurance up to $3,000 out-of-pocket maximum. Deductible does not apply	(Retail) up to 30% coinsurance, depending upon the drug.	Prior authorization required. 30-day supply max. Specialty drugs at retail are subject to the same copays as non-specialty. Some specialty medications are required to be obtained from Sav-Rx specialty pharmacy and/or require enrollment in appropriate patient assistance programs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Physician/surgeon fees	10% Coinsurance	35% Coinsurance[1]	
If you need immediate medical attention	Emergency room care	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Emergency medical transportation	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Urgent care	10% Coinsurance	35% Coinsurance[1]	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	35% Coinsurance[1]	Pre-authorization required for an inpatient admission.
	Physician/surgeon fees	10% Coinsurance	35% Coinsurance[1]	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	35% Coinsurance[1]	Contact Mindful by BlueKC by calling 1-833-964-6338. You may be eligible to receive up to 5 visits through the EAP program at no cost to you. EAP 1-800-624-5544
	Inpatient services	10% Coinsurance	35% Coinsurance[1]	Pre-authorization required for an inpatient admission.
If you are pregnant	Office visits	10% Coinsurance	35% Coinsurance[1]	Coverage for member and spouse only.
	Childbirth/delivery professional services	10% Coinsurance	35% Coinsurance[1]	Coverage for member and spouse only.
	Childbirth/delivery facility services	10% Coinsurance	35% Coinsurance[1]	Coverage for member and spouse only.

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 help recovering or have other special health needs	Home health care	10% Coinsurance	35% Coinsurance[1]	If medically necessary and in lieu of hospitalization..
	Rehabilitation services	10% Coinsurance	35% Coinsurance[1]	Calendar year maximum of 45 visits (combined) for physical therapy, occupational therapy, and speech therapy, with an additional 20 visits for an additional diagnosis or surgery after review by the Fund administrator.
	Habilitation services	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Skilled nursing care	10% Coinsurance	35% Coinsurance[1]	If medically necessary and in lieu of hospitalization.
	Durable medical equipment	10% Coinsurance	35% Coinsurance[1]	----------none----------
	Hospice services	10% Coinsurance	35% Coinsurance[1]	----------none----------
If your child needs dental or eye care	Children's eye exam	No charge up to $400 Deductible does not apply.		Provided through vision coverage. Vision Plan maximum benefits is $400 every two calendar years (beginning each even year) plus $100 annually on safety glasses for **active** employees. (Not covered if waive dental/vision coverage.)
	Children's glasses			
	Children's dental check-up	No Charge for preventive or diagnostic services. 20% coinsurance for basic services Deductible does not apply.	20% Coinsurance[1] Deductible does not apply.	Provided through dental coverage. Dental Plan Maximum Benefit: $1,500 In-Network/ $1,000 Out-of-Network annually (Not covered if waive dental/vision coverage)

[1] If you use an **out-of-network provider**, you are also responsible for any **balance billing** for amounts over reasonable and customary charges. If you reside outside the PPO area, your coinsurance is **20%**.

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
- 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 Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Dental care (Adult), unless you waive dental coverage.
- Hearing aids
- Routine eye care (Adult), unless you waive vision coverage

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 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. 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 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: the Fund Office at **1-816-943-0277**.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-816-943-0277.]

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	$525
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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:	
Cost Sharing	
Deductibles	$525
Copayments	$10
Coinsurance	$1,200
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,795**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$525
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

This EXAMPLE event includes services like:
Primary care physician office visits
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$525
Copayments	$750
Coinsurance	$200
What is not covered	
Limits or exclusions	$25
The total Joe would pay is	**$1,500**

Mia's Simple Fracture

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

The plan's overall deductible	$525
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	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:	
Cost Sharing	
Deductibles	$525
Copayments	$5
Coinsurance	$200
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$730**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact the Fund Office at 1-816-943-0277

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