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 (877) 518-0518. 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 (877) 518-0518 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $260 Person/$780 Family Out-of-Network*: $390 Person/$1,170 Family **Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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 Exam Benefits, In-network Preventive, Dental Benefits, Telehealth Blue KC Virtual Care, Spira Care Clinic, Second Surgical Opinion, Supplemental Accident 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?	Yes. $131 for emergency room services. 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?	Medical - $7,830 per Family Prescription - $6,526 per Individual	The out-of-pocket limit is the most you could pay in a year for covered services. For medical limit, if you have other family members in this plan, the overall family out-of-pocket limit must be met. For prescription limit, each individual in this plan must meet their out-of-pocket limit.
What is not included in the out-of-pocket limit?	Emergency room deductible, copayments for prescription drugs and Telehealth Blue KC Virtual Care, routine physical examination and preventive services, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www.bluekc.com or call (800) 340-0109 for a list of network providers. **Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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	15% coinsurance	25% coinsurance	Spira Care Clinic no copayment, deductible or coinsurance. Telehealth Blue KC Virtual Care Program - no copayment, deductible or coinsurance. Telehealth Blue KC Virtual Care is an In-network benefit only – no coverage for a telemedicine program other than Telehealth Blue KC Virtual Care. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance. Covid testing and other related items at office visits will be covered under standard rates, including the deductible and applicable coinsurance.
	Specialist visit	15% coinsurance	25% coinsurance	----------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)	
	Preventive care/screening/ immunization	No charge		In-network, including Covid vaccine – no deductible. An up-to-date list of covered preventive services can be found at: https://www.healthcare.gov/coverage/preventive-care-benefits/. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. For specific benefits and limitations, see Plan Document*.
If you have a test	Diagnostic test (x-ray, blood work)	No charge up to $100; then 15% coinsurance	No charge up to $100; then 25% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			Prior authorization from BlueKC is required prior to a CAT, PET or MRI scan.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com (Group Number 518) or by calling the Fund Office at (877) 518-0518.	Generic drugs	Retail – Lesser of $13/fill or 100% of drug cost Retail Walk In Mail Order - Lesser of $39/fill or 100% of drug cost Mail Order – Lesser of $21/fill or 100% of drug cost	Not covered	No deductible on Prescription Benefits. Copayment does not apply to deductible. Present Prescription Drug Card at time of retail purchase. If Card is not presented, may submit receipt for reimbursement. Network includes many independent pharmacies and all national pharmacy chains except Walmart. Retail – up to 30-day supply Retail Walk In Mail Order – 90-day supply Mail Order – 90-day supply Prescription Drug Card Out-of-Pocket Limit - $6,526 per calendar year per individual. If generic equivalent is available; you will be required to pay the applicable copayment plus the price difference between the generic drug and the formulary brand name drug. Prescriptions for generic maintenance medication must be obtained through the Retail Walk In Mail Order or Mail Order service after the initial fill and two refills.
	Preferred brand drugs	Retail – Greater of $18/fill or 25% of drug cost –maximum of $196/fill Retail Walk In Mail Order – Greater of $54/fill or 25% of drug cost–maximum of $588/fill Mail Order –$34/fill		
	Non-preferred brand drugs	Retail – Greater of $37/fill or 50% of drug cost – maximum of $326/fill Retail Walk In Mail Order – Greater of $111/fill or 50% of drug cost – maximum of $978/fill Mail Order –$73/fill		

*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)	
	Specialty drugs	Retail – Greater of $18/fill or 25% of drug cost – maximum of $196/fill Retail Walk In Mail Order – Greater of $54/fill or 25% of drug cost – maximum of $588/fill		See the Plan at Section 3.16 for further Limitations & Exceptions*.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			Second Surgical Opinion is covered at 100% and not subject to deductible.
If you need immediate medical attention	Emergency room care	15% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	Subject to $131 Emergency Room Deductible and Major Medical Deductible. Care related to a Medical Emergency – 10% coinsurance, network provider or out-of-network provider, no Emergency Room Deductible. Certain unanticipated out-of-network services shall be subject to in-network coinsurance.
	Emergency medical transportation			----------none----------
If you need immediate medical attention	Urgent care	15% coinsurance		Telehealth Blue KC Virtual Care Program - no copayment, deductible or coinsurance. Telehealth Blue KC Virtual Care is an In-network benefit only – no coverage for a telemedicine program other than Telehealth Blue KC Virtual Care. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	Semi-private room only.
	Physician/surgeon fees			----------none----------

*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 mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	For both inpatient and outpatient treatment, care or treatment must be administered by a medical doctor, psychiatrist, clinical psychologist or licensed practitioner, including a licensed social worker. In-Patient treatment at an Out-of-Network residential treatment center is not covered. Telehealth Blue KC Virtual Care Program for Behavioral Health Therapy and Psychiatry Services - no copayment, deductible or coinsurance. Telehealth Blue KC Virtual Care is an In-network benefit only – no coverage for a telemedicine program other than Telehealth Blue KC Virtual Care. Virtual visits provided by a physician's office in lieu of a face to face visit will be covered under standard rates, including the deductible and applicable coinsurance.
	Inpatient services			
If you are pregnant	Office visits	15% coinsurance	25% coinsurance unless otherwise required by No Surprises Act	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Benefits limited to female Employee or dependent spouse only.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient 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. Benefits limited to female Employee or dependent spouse only.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	Covered only as allowed under Hospice Care Benefit
	Rehabilitation services	15% coinsurance	25% coinsurance	----------none----------
	Habilitation services			Services must be performed by licensed therapist.
	Skilled nursing care			Covered only in cases of physical or rehabilitative therapy.

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)	
	Durable medical equipment			Must meet the Plan definition of Durable Medical Equipment*. Cost of these items shall be limited to an amount determined by the Trustees.
	Hospice services			----------none----------
If your child needs dental or eye care	Children's eye exam	No charge	No charge up to $45	Limited to 2 exams per 12 months.
	Children's glasses	Lenses – No charge Polycarbonate, Scratch Resistant, Rimless Mounting Frames – No charge up to $130 Contacts – No charge up to $130	Lenses – No charge up to $45 – Single up to $65 – Bifocal up to $85 – Trifocal up to $125 – Lenticular Frames – No charge up to $47 Contacts – No charge up to $105	Lenses limited to once per 12 months Frames limited to once per 12 months Contact Lenses are in lieu of frame and lenses and are limited to once per 12 months. See Plan for further benefits and limitations.
	Children's dental check-up	20% coinsurance	20% coinsurance	Not subject to Deductible. Limit two dental check-ups per person per Calendar Year.

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.)

- Bariatric surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery (if as a result of a surgical procedure covered under the Plan, injuries while covered under the Plan or reconstruction due to a mastectomy)
- Dental care (adult)
- Hearing aids ($1,000 per ear each 36 months)
- Home health care (as allowed under Hospice Care Benefit)
- Private-duty nursing
- Routine eye care (adult)

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

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 1-877-518-0518 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 (877) 518-0518.

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** **$260**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$260
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,130**

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

- **The plan's overall deductible** **$260**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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:

Cost Sharing	
Deductibles	$260
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$880**

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

- **The plan's overall deductible** **$260**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$810**

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