This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling (816) 361-0206.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$600** per person **/$1,200** family; Out-of-Network: **$600** per person **/$1,200** family; Does not apply to in-network Routine Care, Wellness, Dental, Vision, or Prescription Drug Benefits.	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, prescription drugs: **$200** per person **/$400** per family. 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. Medical: **$4,600** per person in-network / **$9,200** per family in-network. Prescription Drugs: **$2,550** per person / **$5,100** per family.	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?	Premiums, balance-billed charges, health care this plan doesn't cover, and out-of-pocket costs for dental and vision benefits. Medical expenses apply to medical limit; prescription drug expenses apply to prescription drug limit.	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 *specific* coverage limits, such as limits on the number of office visits.

Questions: Call (816) 361-0206.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (816) 361-0206 to request a copy.

Does this plan use a network of providers?	Yes. For a list of **network providers** , see www.bluekc.com or call 888-989-8842.	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 plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan 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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	In-network Nurse Practitioner Retail Clinics and AmWell "telehealth" visits paid at 100% after $10 copayment.
	Specialist visit	20% coinsurance	40% coinsurance	----------none----------
	Other practitioner office visit (e.g. chiropractor/acupuncture)	Not Covered	Not Covered	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization (i.e. Routine/Preventive Care Benefits)	No Charge	No Charge up to $300; then 40% coinsurance	Age, gender and frequency limits may apply to some preventive services. Services not considered preventive services under the Affordable Care Act (ACA) may be excluded from coverage or subject to other cost share amounts.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	----------none----------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-516-3121	Generic drugs	$15 copayment for up to 34 Day Supply at Retail; $30 copayment for 90 Day Supply at LDI Mail Order; Special copayments for generic statins: $10 copayment for up to 34 Day Supply at Retail; $20 copayment for 90 Day Supply at LDI Mail Order	Not Covered	Proton Pump Inhibitors and Non-Sedating Antihistamines are not covered (except as provided on page 33 of the SPD). Specialty Drugs and new-to-market drugs require prior authorization, must be Medically Necessary, and must be filled through LDI mail order. Prescription drugs that are considered preventive services under the ACA are covered at 100% by this Plan and are not subject to the prescription drug deductibles and copayments. Anti-diabetics and anti-cholesterol drugs (statins) are subject to LDI's Step Therapy Program.
	Preferred brand formulary drugs	Up to 34 Day Supply: Retail: $30 copayment 90 Day Supply: LDI Mail Order: $60 copayment	Not Covered	
	Non-formulary brand drugs	Up to 34 Day Supply: Retail: $50 copayment 90 Day Supply: LDI Mail Order: $100 copayment	Not Covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Specialty drugs	Up to 30 Day Supply subject to the following copayments at LDI Mail Order: Generic: $15 Preferred Brand: $30 Non-Formulary: $50	Not Covered	Maintenance medications must be filled by LDI mail. Additional limits apply to Prescription Drug Benefits, see page 32 and 33 of SPD and Benefit Alerts #22 and 35.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	----------none----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	20% coinsurance	40% coinsurance	In-network rates apply if services provided in connection with emergency medical condition.
	Emergency medical transportation	20% coinsurance	40% coinsurance	In-network rates apply if services provided in connection with emergency medical condition.
	Urgent care	20% coinsurance	40% coinsurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Out-of-network coverage available if stay due to medical emergency.
	Physician/surgeon fee	20% coinsurance	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	100% coverage if outpatient treatment is the result of a referral from the Medical Review Office of the Employee Assistance Program. No coverage for claims incurred at out-of-network residential treatment facility.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	100% up to $7,500; 20% coinsurance thereafter	40% coinsurance	
If you are	Prenatal and postnatal care	20% coinsurance	40% coinsurance	No coverage for services in

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
pregnant	Delivery and all inpatient services	20% coinsurance	Not Covered	connection with a pregnancy of a Dependent child except in limited circumstances when considered preventive under the ACA.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be Medically Necessary, be part of a Physician-established plan, and the Covered Person would have to be hospitalized if the services were not available in his/her home.
	Rehabilitation services	20% coinsurance	Not Covered	Must be Medically Necessary and prescribed by a Physician.
	Habilitation services	Not Covered	Not Covered	----------none----------
	Skilled nursing care	20% coinsurance	Not Covered	Must be Medically Necessary, be part of a Physician-established plan, and the Covered Person would have to be hospitalized if the services were not available in his/her home.
	Durable medical equipment	20% coinsurance	40% coinsurance	Must be Medically Necessary and prescribed by a Physician.
	Hospice service	20% coinsurance	40% coinsurance	Maximum of 210 days.
If your child needs dental or eye care	Eye exam	Up to $50/year		No limit for Covered Persons under age 19.
	Glasses	Frames – up to $75 /year for Eligible Employees and every 2 years for Dependents Contact Lenses – up to $100/year Lenses - Single vision: up to $50/year Bifocal: up to $85/year Trifocal: up to $95/year		Dollar limits for Covered Persons under age 19 do not apply to frames and lenses which meet the minimum specifications to allow for necessary vision correction.
	Dental check-up	Delta Dental: 10% coinsurance; Other: 20% coinsurance	40% coinsurance	Maximum benefit $1,500 per person per Calendar Year. No limit for Covered Persons under age 19.

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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Habilitation services
- Infertility treatment
- Long-term care (unless needed for acute Medical Care)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs (except in limited circumstances when they are considered preventive under the Affordable Care Act)

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.)

- Dental care (Adult)
- Hearing aids ($2,000 every 5 years)
- Routine eye care (Adult)

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 plan at (816) 361-0206. 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 (816) 361-0206 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.**

Language Access Services:

Para obtener asistencia en Español, llame al (816) 756-3313.

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** $5,440
- **Patient pays** $2,100

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	$620
Copays	$0
Coinsurance	$1,330
Limits or exclusions	$150
Total	**$2,100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,570
- **Patient pays** $1,830

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	$800
Copays	$590
Coinsurance	$360
Limits or exclusions	$80
Total	**$1,830**

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.