BAC Local Union 15 Welfare Fund: Actives & Pre-Medicare Retirees

Coverage for: Employees & 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, 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	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 Care, Preventive, Flu Shot, Telehealth Amwell 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,500 per Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments for prescription drugs, acupuncture, chiropractic benefits, well child benefits, 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.
Will you pay less if you use a network provider?	Yes. See www.mybluekc.com or call (800) 810-2583 for a list of 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	30% coinsurance	Telehealth Amwell Program - no copayment, deductible or coinsurance. Telehealth Amwell is an In-network benefit only.
	Specialist visit	10% coinsurance	30% coinsurance	----------none----------
	Preventive care/screening/ immunization	No charge	30% coinsurance	In-network – No Deductible. 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 the plan document at Section Four, subsection O.*
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	----------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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com or by calling the Pharmacy Benefit Manager at phone number listed on your prescription ID card.	Generic drugs	Retail – Lesser of $10 or 100% of drug cost (up to 34-day supply); Lesser of $20 or 100% of drug cost (up to 90-day supply); Mail Order – Lesser of $20 or 100% of drug cost (up to 90-day supply)	Retail – Lesser of $10 or 100% of drug cost (up to 34-day supply); Lesser of $20 or 100% of drug cost (up to 90-day supply); Mail Order – Lesser of $20 or 100% of drug cost (up to 90-day supply)	No deductible on Prescription Benefits. Copayment does not apply to deductible or out-of-pocket limit. If a participant chooses to utilize a brand drug 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 copayment. Without such letter of necessity, the participant will be required to pay the Non-preferred drug copayment plus the difference in cost between the brand drug and generic.
	Preferred brand drugs	Retail – Greater of $25 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $50 or 20% of drug cost (up to 90-day supply)	Retail – Greater of $25 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $50 or 20% of drug cost (up to 90-day supply)	
	Non-preferred brand drugs	Retail – Greater of $40 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $80 or 20% of drug cost (up to 90-day supply)	Retail – Greater of $40 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $80 or 20% of drug cost (up to 90-day supply)	
	Specialty drugs	Retail – Greater of $40 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $80 or 20% of drug cost (up to 90-day supply)	Retail – Greater of $40 or 25% of drug cost (up to 34-day supply); Mail Order – Greater of $80 or 20% of drug cost (up to 90-day supply)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	----------none----------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room care	10% coinsurance after $100 copayment	30% coinsurance after $100 copayment	$100 copayment waived if Covered Person admitted to hospital.
	Emergency medical transportation	10% coinsurance	30% 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)	
	Urgent care	10% coinsurance	30% coinsurance	Telehealth Amwell Program - no copayment, deductible or coinsurance. Telehealth Amwell is an In-network benefit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Semi-private room only.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	Service or treatment must be provided by a Legally Qualified Substance Use Professional. Treatments for behavior disorders are not covered.
	Inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	In-patient stay of at least 48 hours (vaginal delivery) or at least 96 hours (cesarean section delivery). Pregnancy of a dependent child not covered.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Home Health Care covered only as allowed under Hospice Benefit.
	Rehabilitation services	10% coinsurance	30% coinsurance	Treating Physician must submit a plan of treatment to the Fund Office for approval prior to beginning therapy.
	Habilitation services	10% coinsurance	30% coinsurance	Treating Physician must submit a plan of treatment to the Fund Office for approval prior to beginning therapy.
	Skilled nursing care	10% coinsurance	30% coinsurance	----------none----------
	Durable medical equipment	10% coinsurance	30% coinsurance	Must be certified as medically necessary by the prescribing physician. Must not be beyond the appropriate level of performance and quality required under the circumstances.
	Hospice services	10% coinsurance	30% coinsurance	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 medically necessary vision correction.
	Children's glasses			
	Children's dental check-up	20% coinsurance	20% coinsurance	Dental Benefits will be limited to a $1,750 per person per Calendar Year maximum. Limit two dental check-ups per person per Calendar Year. Limit includes charges for check-ups and other dental services and does not apply to Covered Persons under age 19.

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.)

- Cosmetic surgery (unless as a result of a surgical procedure covered under the Plan)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs (except those covered under ACA preventive care guidelines)

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

- Acupuncture
- Bariatric surgery (through Blue Distinction Center)
- Chiropractic care
- Dental care (adult)
- Hearing aids
- 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
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,700**

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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,260**

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$100
Coinsurance	$200
What isn't covered	
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.