Mo-Kan Sheet Metal Workers Welfare Fund: Plan A

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2024

Coverage for: Family | **Plan Type:** PPO

000000Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Individual: $**500 person with valid physical /$1500.00 without valid physical. **Family**: $1000 W/Valid Physical $3000.00 without valid physical Does not apply to preventive care	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?	No.	You do not have to meet **deductibles** for specific services, see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For in-network providers **$4000.00** person**/$8000.00**family For out-of-network providers **$8000.00** person**$ 16,000.00** 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?	Balance-billed charges, premiums, copayments, and health care this plan does not cover.	Even though you pay these expenses, they do not 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 1-866-531-5488** for a list of in-network 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 do not 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 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-816-531-0334 or visit us at www.mokansheetmetal.org.

If you are not clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-816-531-0334 to request a copy.

- **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 in-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	50% coinsurance	————————none————————
	Specialist visit	20% coinsurance	50% coinsurance	————————none————————
	Other practitioner office visit	20% coinsurance	50% coinsurance	————————none————————
	Preventive care/screening/immunization	Benefit paid: 100%. 20% coinsurance	50% coinsurance	Several routine screenings are covered at 100%. Please see the plan document for a complete listing.
If you have a test	Diagnostic test (x-ray, blood work)	Benefit paid:100% up to $150 20% coinsurance	50% coinsurance	Lab work done at a Quest Diagnostics facility; services are paid at 100%
	Imaging (CT/PET scans, MRIs)	Benefit paid: 100% up to $150 20% coinsurance	50% coinsurance	————————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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mokansheetmetal.org.	Generic drugs	$15.00copay/ prescription or $25.00copay for 90 day supply mail order	Member pays out of pocket and can be reimbursed	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	50% up to $65 or 50% up to $130 for 90 day supply mail order	Member pays out of pocket and can be reimbursed	——————none——————
	Non-preferred brand drugs	50% up to $65 or 50% up to $130 for 90 day supply mail order	Member pays out of pocket and can be reimbursed	——————none——————
	Specialty drugs	50% up to $65 or 50% up to $130 for 90 day supply mail order	Member pays out of pocket and can be reimbursed	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$200 co-pay 20% coinsurance	$200 co-pay 50% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	50% coinsurance	——————none——————
	Urgent care	20% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay, 20% coinsurance	$800 copay, 50% coinsurance	All inpatient stays must be prior authorized.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	——————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
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	50% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	$400 copay, 20% coinsurance	$800 copay, 50% coinsurance	Copayment waived if admitted twice in a six-month period
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	————————none————————
	Substance use disorder inpatient services	$400 copay, 20% coinsurance	$800 copay, 50% coinsurance	Copayment waived if admitted twice in a six-month period
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	————————none————————
	Delivery and all inpatient services	$400 copay, 20% coinsurance	$800 copay, 50% coinsurance	————————none————————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	————————none————————
	Rehabilitation services	20% coinsurance	50% coinsurance	————————none————————
	Habilitation services	20% coinsurance	50% coinsurance	————————none————————
	Skilled nursing care	20% coinsurance	50% coinsurance	————————none————————
	Durable medical equipment	20% coinsurance	50% coinsurance	————————none————————
	Hospice service	20% coinsurance	50% coinsurance	————————none————————
If your child needs dental or eye care	Eye exam	Free with Davis vision	Free with Davis vision	
	Glasses	350.00 with Davis	175.00 with Davis	
	Dental check-up	No charge	No charge	Paid @ 100% preventative.

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Acupuncture

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

- Bariatric surgery
- Dental Care (Adult $1600.00 benefit)
- Chiropractic care (40 visits per year)
- Routine eye care (Adult $350.00 benefit)
- Routine foot care
- Hearing aids
- Weight loss programs

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 1-866-531-5488. 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 Mo-Kan Sheet Metal Workers Welfare Fund at 1-866-531-5488 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-531-5488.

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.

Do not 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** $5,360
- **Patient pays** $2180.00

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	$500
Copays	$400
Coinsurance	$1280.00
Limits or exclusions	$0
Total	**$2180.00**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

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	$500
Coinsurance	$1100
Limits or exclusions	$0
Total	**$1,600**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services and are not 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 is not 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 cannot 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. 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.