

Mo-Kan Sheet Metal Workers Welfare Fund: Plan A

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

Coverage Period: 01/01/2026

Coverage for: Family | Plan Type: PPO

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Individual: \$500 with valid physical \$1500 without valid physical. Family: \$1000 with valid physical \$3000 without valid physical <u>Does not apply to preventive care</u>	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You do not have to meet <u>deductibles</u> for specific services, see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. In-network providers: \$4000 individual / \$8000 family Out-of-network providers: \$8000 individual / \$16,000 family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Balance-billed charges, premiums, and health care this Plan does not cover.	Even though you pay these expenses, they do not count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	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 <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You do not need a referral to see a specialist.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

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

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- **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% after deductible	50% after deductible	—————none—————
	Specialist visit	20% after deductible	50% after deductible	—————none—————
	Other practitioner office visit	20% after deductible	50% after deductible	—————none—————
	Preventive care/screening/immunization	Plan pays 100%.	50% after deductible	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)	Plan pays 100% up to \$150 (combined w/imaging), then 20% after deductible	50% after deductible	Lab work done at a Quest Diagnostics facility; services are paid at 100%
	Imaging (CT/PET scans, MRIs)	Plan pays 100% up to \$150 (combined w/ diagnostic test), then 20% after deductible	50% after deductible	—————none—————

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.MokanSheetMetal.org .	Generic drugs	Up to \$15 for 30-day supply Up to \$25 for 90-day supply	Member pays out of pocket and can be reimbursed through Pharmacy Benefit Manager (PBM)	Covers up to a 30-day supply (retail prescription); 31–90-day supply (mail order prescription)
	Preferred brand drugs	50% up to \$65 for 30-day supply 50% up to \$130 for 90-day supply	Member pays out of pocket and can be reimbursed through Pharmacy Benefit Manager (PBM)	—————none—————
	Non-preferred brand drugs	50% up to \$65 for 30-day supply 50% up to \$130 for 90-day supply	Member pays out of pocket and can be reimbursed through Pharmacy Benefit Manager (PBM)	—————none—————
	Specialty drugs	50% up to \$65 for 30-day supply 50% up to \$130 for 90-day supply	Member pays out of pocket and can be reimbursed through Pharmacy Benefit Manager (PBM)	—————none—————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	50% After deductible	—————none—————
	Physician/surgeon fees	20% after deductible	50% After deductible	—————none—————
If you need immediate medical attention	Emergency room services	\$200 copay, then 20% after deductible	\$200 copay, then 50% after deductible	—————none—————
	Emergency medical transportation	20% after deductible	50% after deductible	—————none—————
	Urgent care	20% after deductible	50% after deductible	—————none—————
If you have a hospital stay All inpatient stays must be prior authorized	Facility fee (e.g., hospital room)	\$400 copay, then 20% after deductible	\$800 copay, then 50% after deductible	Copayment waived if admitted twice in a six-month period
	Physician/surgeon fee	20% after deductible	50% after deductible	Copayment waived if admitted twice in a six-month period

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% after deductible	50% after deductible	—————none—————
	Mental/Behavioral health inpatient services	\$400 copay, then 20% after deductible	\$800 copay, then 50% after deductible	Copayment waived if admitted twice in a six-month period
	Substance use disorder outpatient services	20% after deductible	50% after deductible	—————none—————
	Substance use disorder inpatient services	\$400 copay, then 20% after deductible	\$800 copay, then 50% after deductible	Copayment waived if admitted twice in a six-month period
If you are pregnant	Prenatal and postnatal care	20% after deductible	50% after deductible	No coverage for Dependent Children
	Delivery and all inpatient services	\$400 copay, then 20% after deductible	\$800 copay, then 50% after deductible	No coverage for Dependent Children
If you need help recovering or have other special health needs	Home health care	20% after deductible	50% after deductible	—————none—————
	Rehabilitation services	20% after deductible	50% after deductible	—————none—————
	Habilitation services	20% after deductible	50% after deductible	—————none—————
	Skilled nursing care	20% after deductible	50% after deductible	—————none—————
	Durable medical equipment	20% after deductible	50% after deductible	—————none—————
	Hospice service	20% after deductible	50% after deductible	—————none—————
If your child needs dental or eye care	Eye exam	Plan pays 100%	Reimbursed up to \$40	
	Glasses or Contacts	\$350 material allowance	Reimbursed up to \$245	
	Dental check-up	Plan pays 100%	Plan pays 100% of allowable	Limit - Twice per calendar year

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 <u>excluded services</u> .)	
<ul style="list-style-type: none"> • Cosmetic surgery • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing • Acupuncture

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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

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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.*—————

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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
Limits or exclusions	\$0
Total	\$2180

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

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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.

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