Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

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PLUMBING AND PIPEFITTING INDUSTRY HEALTH AND WELFARE FUND OF KANSAS: Board of Trustees

Coverage Period: 08/01/2023-07/31/2024

Coverage for: Individual + Family | Plan Type: POS

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, see www.HealthReformPlanSBC.com or call 1-800-370-4526. 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 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each plan year, $0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Not applicable.	This plan does not have an overall deductible.
Are there other deductibles for specific services?	Yes. $75 / individual / $150 / family for dental coverage (waived if in-network provider). 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?	In-Network: Individual $2,000 / Family $4,000. Out-of-Network: Individual $2,500 / Family $5,000.	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, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, & 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.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers. Call 1-800-234-3375 for dental in-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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	50% coinsurance	70% coinsurance	None
	Specialist visit	50% coinsurance	70% coinsurance	Chiropractic care is limited to $800 / family per calendar year.
	Preventive care /screening /immunization	50% coinsurance	70% coinsurance	Flu shots and COVID-19 testing and vaccines are covered at 100%.
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	70% coinsurance	Preauthorization required for certain procedures.
	Imaging (CT/PET scans, MRIs)	50% coinsurance	70% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	50% coinsurance (retail & mail order)	50% coinsurance after copay/ prescription: 50% (retail)	Covers 30 day supply (retail), 31-90 day supply (retail at Extended Day Supply Network Pharmacy & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written; cost difference penalty doesn't apply to out-of-pocket limit. Review your Aetna Extended Day Supply Network provider directory for a list of network providers.
	Preferred brand drugs	50% coinsurance (retail & mail order)	50% coinsurance after copay/ prescription: 50% (retail)	
	Non-preferred brand drugs	50% coinsurance (retail & mail order)	50% coinsurance after copay/ prescription: 50% (retail)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	Covers 30 day supply. All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	70% coinsurance	Preauthorization is required.
	Physician/surgeon fees	50% coinsurance	70% coinsurance	None
If you need immediate medical attention	Emergency room care	50% coinsurance	50% coinsurance	Out-of-network emergency use paid the same as in-network.
	Emergency medical transportation	50% coinsurance	50% coinsurance	Out-of-network emergency use paid the same as in-network.

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Urgent care	50% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	70% coinsurance	Preauthorization is required.
	Physician/surgeon fees	50% coinsurance	70% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 50% coinsurance	Office & other outpatient services: 70% coinsurance	Preauthorization required for certain services.
	Inpatient services	50% coinsurance	70% coinsurance	Preauthorization required for certain services.
If you are pregnant	Office visits	50% coinsurance	70% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization may be required for out-of-network services.
	Childbirth/delivery professional services	50% coinsurance	70% coinsurance	
	Childbirth/delivery facility services	50% coinsurance	70% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	70% coinsurance	Preauthorization is required.
	Rehabilitation services	50% coinsurance	70% coinsurance	90 visits per calendar year for Speech Therapy.
	Habilitation services	50% coinsurance	70% coinsurance	None
	Skilled nursing care	50% coinsurance	70% coinsurance	Preauthorization is required.
	Durable medical equipment	50% coinsurance	70% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	50% coinsurance	70% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to $600 / family per calendar year.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge	No charge	Limited to $1,500 / individual per calendar year. Benefits provided by Delta Dental. You are responsible for charges above the reasonable and customary charge for a check-up by an out-of-network provider.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- 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.)

- Chiropractic care - $800 per family/calendar year.
- Dental care (Delta Dental)
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Routine eye care
- Private-duty nursing

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:

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

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 on how 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance

Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

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 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.

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	**$0**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	$0
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	$0
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$0**
Specialist coinsurance	**50%**
Hospital (facility) coinsurance	**50%**
Other coinsurance	**50%**

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	$0
Copayments	$0
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).