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 (816) 756-3313. 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 (816) 756-3313 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $1,250/individual or $2,500/family **Certain Out-of-Network claims are treated as In-Network claims as required by No Surprises Act.*	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. In-Network Nurse Practitioner Retail Clinic Visit Benefit, In-Network Organ & Tissue Transplant, In-Network Urgent Care, Teladoc Virtual, Preventive Care, Sword Health virtual physical and pelvic therapy, Prescription and Vision 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. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	**Medical** In-Network*- $4,600/individual or $9,200/family **Prescription** In-Network- $4,600/individual or $9,200/family **Certain Medical Out-of-Network claims are treated as Medical In-Network claims as required by No Surprises Act.*	The out-of-pocket limit is the most you could pay in a year for covered services. For medical limit, if you have other family members in this plan, they have to meet their own medical out-of-pocket limit until the overall family medical out-of-pocket limit has been met. For prescription limit, if you have other family members in this plan, they have to meet their own prescription out-of-pocket limit until the overall family prescription out-of-pocket limit has been met
What is not included in the out-of-pocket limit?	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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes.* See www.umr.com or call (800) 810-2583 for a list of network providers. **Out-of-Network providers* *may be treated as* *In-Network providers* *as required by No Surprises Act.*	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	20% coinsurance	Not covered	Teladoc Virtual Care – no copayment, deductible or coinsurance. Teladoc Virtual Care is an In-Network Benefit only – no coverage for any other telemedicine program.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No charge	Not covered	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.*
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	----------none----------
	Imaging (CT/PET scans, MRIs)			Subject to review for medical necessity.

*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 by calling Sav-Rx Prescription Services at (800) 228-3108. Active and Non-Medicare Retirees may also get additional information at www.savrx.com.	Generic drugs	Retail – $10 Retail 90 Days – $25 Mail Order – $25	Not covered	No deductible on Prescription Benefits. Present Prescription Drug Card at time of retail purchase. If Card is not presented, may submit receipt for reimbursement. Active and Non-Medicare Retiree Retail is up to 34-day supply. Retail 90 Days is available at all Sav-Rx "walk-in" network pharmacy locations. All Mail Order is 90-day supply. If generic equivalent is available; you will be required to pay the applicable copayment plus the price difference between the generic drug and the formulary brand name drug. Prescriptions for maintenance medication must be obtained through the mail order service after the initial fill and two refills. See the Plan for Prescription Exclusions.*
	Preferred brand drugs	Retail – Greater of $30 or 25% of drug cost Retail 90 Days – Greater of $75 or 25% of drug cost Mail Order – $60 or 25% of drug cost		
	Non-preferred brand drugs	Retail – Greater of $50 or 40% of drug cost Retail 90 Days – Greater of $125 or 35% of drug cost Mail Order – $100 or 35% of drug cost		
	Specialty drugs	Generic – $10 Preferred brand – Greater of $30 or 25% of drug cost Non-Preferred brand – Greater of $50 or 40% of drug cost	Not covered	All specialty drugs require preauthorization. 90-day supply is available for certain specialty drugs. See the Plan for Prescription Exclusions.*

*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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance	Not covered unless otherwise required by No Surprises Act	----------none----------
	Emergency medical transportation			
	Urgent care			Teladoc Virtual Care – no copayment, deductible or coinsurance. Teladoc Virtual Care is an In-Network Benefit only – no coverage for any other telemedicine program.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered unless otherwise required by No Surprises Act	Semi-private room only. Inpatient stays require preauthorization.
	Physician/surgeon fees			----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered unless otherwise required by No Surprises Act	Teladoc Virtual Care – no copayment, deductible or coinsurance. Teladoc Virtual Care is an In-Network Benefit only – no coverage for any other telemedicine program. For both inpatient and outpatient treatment, care or treatment must be administered by a duly licensed clinical psychiatrist, Board certified psychologist or counselor working under the direct supervision of a psychologist or psychiatrist.
	Inpatient services			

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 are pregnant	Office visits	20% coinsurance	Not covered unless otherwise required by No Surprises Act	Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). Benefits limited to female Employee or dependent spouse.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			In-patient stay of at least 48 hours (vaginal delivery) or at least 96 hours (cesarean section delivery). Benefits limited to female Employee or dependent spouse.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Limited to 60 visits per Calendar Year. 1 visit is equal to 4 hours. Visits longer than 4 hours in the same day will count for multiple visits.
	Rehabilitation services			Treatment for certain conditions with Sword Health virtual physical and pelvic therapy – no copayment, deductible or coinsurance. All other in-network physical therapy services subject to deductible and coinsurance.
	Habilitation services			Limited to certain speech and occupational therapy services. Treatment for certain conditions with Sword Health virtual physical and pelvic therapy – no copayment, deductible or coinsurance. All other in-network physical therapy services subject to deductible and coinsurance.
	Skilled nursing care			Must be admitted within 7 days of a 3-day Hospital or Skilled Nursing Facility confinement. Other limitations may apply. See the Plan for further details.*

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 help recovering or have other special health needs	Durable medical equipment	20% coinsurance	Not covered	Orthotics 50% In-Network. Must meet the Plan definition of Durable Medical Equipment*.
	Hospice services			----------none----------
If your child needs dental or eye care	Children's eye exam	No charge for individuals under age 19		Limited to 1 exam per calendar year.
	Children's glasses	No charge for individuals under age 19		Lenses & Frames **or** Contact Lenses for children under age 19 are limited to once per Calendar Year.
	Children's dental check-up	No charge		Not subject to deductible. Limit two dental check-ups per person per Calendar Year.

*For more information about limitations and exceptions, see summary plan description (SPD).

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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (unless Medically Necessary)
- 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.)

- Chiropractic care (up to 24 manipulations per calendar year)
- Cosmetic surgery (if as a result of a surgical procedure covered under the Plan, an accident while covered under the Plan or reconstruction due to a mastectomy)
- 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 1-816-756-3313 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
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 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 (816) 756-3313.

*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** **$1,250**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,250
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,620**

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

- **The plan's overall deductible** **$1,250**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,250
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,670**

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

- **The plan's overall deductible** **$1,250**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,250
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,560**

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