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) 737-5959. 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 www.healthcare.gov/sbc-glossary or call (816) 737-5959 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400 per person *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.
Are there services covered before you meet your deductible?	Yes. Non-lab charges associated with physical exams, Prescription Drugs, Teladoc Services, Union Health & Wellness Center, Dental, Hearing Care, Vision Care, Shingles Vaccines, In-Network Well Baby/Child Care Office Visit, Mental Health Services, and Preventive Care 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?	Yes. $135 per person / $270 per family for Prescription Drug Benefits and $25 per family for Dental Benefits. 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*: $6,299 per person Out-of-Network: None **Certain out-of-network claims are treated as 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.
What is not included in the out-of-pocket limit?	Copayments, Dental, Hearing Care, Prescription Drugs, Vision Care, premiums, deductibles, Out-of-Network benefits, motorized wheelchairs or scooters, balance billed 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.umr.com or call (800) 826-9781 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.

Important Questions	Answers	Why This Matters:
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 copayment per visit	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter)	No charge for services at Union Health & Wellness Center for Participant and Dependents age 2 and over. Teladoc – no copayment, deductible or coinsurance. This program is an In-Network benefit only – no coverage for any program other than Teladoc.
	Specialist visit	$27 copayment per visit		No deductible for Mental Health Services
	Preventive care/screening/ immunization	No charge		In-Network only: no charge for well baby office visits and preventive services. 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 Plan Document*
If you have a test	Diagnostic test (x-ray, blood work)	Preferred (you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter)	----------none----------
	Imaging (CT/PET scans, MRIs)			

*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 the Fund Office at (816) 737-5959.	Generic drugs	Retail – Greater of $15 copayment per prescription or 10% of cost Mail order or CVS Retail Pharmacy - $25 copayment per prescription	Retail – Greater of $15 or 10% of cost	Retail Out-of-Network member pays 100% then submits for reimbursement. Retail copayment is for 34-day supply. Mail order or CVS Retail Pharmacy copayment is limited to 90-day supply. If a participant chooses to utilize a brand drug when a generic equivalent is available, the participant will be required to pay the generic drug copayment or coinsurance plus the difference in cost between the brand drug and generic.
	Preferred brand drugs	Retail – Greater of $40 copayment per prescription or 30% of cost Mail order or CVS Retail Pharmacy - $100 copayment per prescription	Retail – Greater of $40 or 30% of cost	
	Non-preferred brand drugs			
	Specialty drugs			

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)	Preferred (you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter) unless otherwise required by No Surprises Act	----------none----------
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care			----------none----------
	Emergency medical transportation			
	Urgent care			Teladoc – no copayment, deductible or coinsurance. This program is an In-Network benefit only – no coverage for any program other than Teladoc.
If you have a hospital stay	Facility fee (e.g., hospital room)	Preferred (you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter) unless otherwise required by No Surprises Act	Semi-private room only. Preauthorization required for inpatient hospital stay.
	Physician/surgeon fees			Preauthorization required for some inpatient surgery. See Plan Document for complete list.*

*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 mental health, behavioral health, or substance abuse services	Outpatient services	Preferred(you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter) unless otherwise required by No Surprises Act	Preauthorization required for inpatient hospital stay. No deductible for Mental Health Services
	Inpatient services			
If you are pregnant	Office visits	Preferred (you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter) unless otherwise required by No Surprises Act	No charge for Maternity Management Program. Limited to a Participant or Dependent Spouse. 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).
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Limited to a Participant or Dependent Spouse. Inpatient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery.
If you need help recovering or have other special health needs	Home health care	Preferred (you will pay 20% of first $4,000 in Covered Charges, then 5% of next $109,989 in Covered Charges, then 0% of Covered Charges thereafter)	Standard (you will pay 30% of the first $5,500 in Covered Charges then 10% of Covered Charges thereafter)	Preauthorization required.
	Rehabilitation services			----------none----------
	Habilitation services			
	Skilled nursing care			Preauthorization is required.
	Durable medical equipment			Preauthorization is required. Limits may apply.
	Hospice services			----------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 your child needs dental or eye care	Children's eye exam	$10	No charge up to $40	One examination per calendar year.
	Children's glasses	Frames – No charge up to $50 wholesale/$130 retail Lenses - $10 single vision	Frames – No charge up to $45 Lenses – No charge up to $40 single vision	Limited to once per calendar year. Additional benefits available for contacts, bifocals, etc.
	Children's dental check-up	No charge		Other benefits available generally subject to the Dental Benefit deductible and coinsurance.

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
- Infertility treatment
- 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 (up to 30 visits/year)
- Dental care (adult)
- Hearing aids
- Private-duty nursing
- Routine eye care (adult)

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

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 (816) 737-5959 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) 737-5959.

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** *(combined medical and prescription deductibles)* **$535**
- **Specialist copayment** **$27**
- **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	$400
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

- **The plan's overall deductible** *(combined medical and prescription deductibles)* **$535**
- **Specialist copayment** **$27**
- **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	$500
Copayments	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** *(combined medical and prescription deductibles)* **$535**
- **Specialist copayment** **$27**
- **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	$400
Copayments	$80
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$880**

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