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) 361-0206. 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) 361-0206 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network*: $300 Person / $600 Family Out-of-Network: $300 Person / $600 Family	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 Routine Care, Wellness, nurse practitioner clinics, Teladoc Virtual Care, certain mental health services, Dental, Vision and Prescription Drug 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* $3,300 Person / $6,600 Family **Certain out-of-network claims are treated as in-network claims as required by No Surprises Act.* **Prescription:** In-Network $2,550 Person / $5,100 Family	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?	Dental and vision benefits, charges for Out-of-Network providers except Emergency Services, premiums, balance billing charges and health care this plan doesn't cover. The amount of any coupon, rebate or other financial assistance applied directly towards a specialty drug copayment at the time of purchase.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

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

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes*. See www.aetna.com or call (816) 361-0206 for a list of network providers. **Out-of-network providers* may be treated as *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
		In-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	15% coinsurance	40% coinsurance	In-Network Nurse Practitioner Retail Clinics paid at 100% after $15 copayment with no coinsurance or deductible. Teladoc Virtual Care visits paid at 100% with no copayment, coinsurance or deductible.
	Specialist visit			----------none----------
	Preventive care/screening/ immunization	No charge	No charge up to $300; then 40% coinsurance	Age, gender and frequency limits may apply to some 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.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	40% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)			May be 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
		In-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 at www.savrx.com or by calling the Fund Office at (816) 361-0206.	Generic drugs	Retail – $15 copayment per prescription (up to 34-day supply); Mail Order & Walk-In Mail Order – $30 copayment per prescription (90-day supply) Special copayment for generic statins: Retail – $10 copayment per prescription (up to 34-day supply) Mail Order & Walk-In Mail Order - $20 copayment per prescription (90-day supply)	Not covered	Non-Sedating Antihistamines, Fertility drugs, and cosmetic drugs are not covered. Proton Pump Inhibitors are not covered except as provided on page 127 of the SPD.* Additional limits also apply and are described on pages 126 and 127 of the SPD and Benefit Alerts #22 and #35. Specialty drugs , compound medication over $100, and opioids over a certain quantity require preauthorization and must be medically necessary. Brand drugs with generic equivalent subject to brand copayment plus price difference between generic and brand name drugs, except for anyone who is Medicare Primary. Prescription drugs that are considered preventive services under the ACA are covered at 100% by this Plan and are not subject to the prescription drug copayments. Anti-diabetics, anti-cholesterol drugs (statins), triptans for migraines, antidepressants, sleep aids, nasal sprays, osteoporosis medications, anti-inflammatories, Lyrica, overactive bladder drugs, and glaucoma eye drops are subject to Sav-Rx's Step Therapy Program, except for anyone who is Medicare Primary. Maintenance medications and certain specialty drugs must be filled by Sav-Rx mail or Sav-Rx Walk-In Mail Retail Pharmacy, except for anyone who is Medicare Primary. Alternate copayments may apply to certain specialty drugs eligible for manufacturer discount coupons applied by Sav-Rx at time of purchase. The Plan does not cover medications that are included on Sav-Rx's list of medication that have equally effective equivalents and are not proven to work better than the more cost effective option.
	Preferred brand drugs	Retail – $30 copayment per prescription (up to 34-day supply); Mail Order & Walk-In Mail Order – $60 copayment per prescription (90-day supply)	Not covered	
	Non-preferred brand drugs	Retail – $50 copayment per prescription (up to 34-day supply); Mail Order & Walk-In Mail Order – $100 copayment per prescription (90-day supply)	Not covered	
	Specialty drugs	Mail Order – (up to 30-day supply): Generic: $15 copayment per prescription Preferred Brand: $30 copayment per prescription Non-Formulary: $50 copayment per prescription Mail Order – (up to 90-day supply): Generic: $30 copayment per prescription Preferred Brand: $60 copayment per prescription Non-Formulary: $100 copayment per prescription	Not covered	

*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
		In-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)	15% coinsurance	40% coinsurance	----------none----------
	Physician/ surgeon fees		40% coinsurance unless otherwise required by No Surprises Act	
If you need immediate medical attention	Emergency room care	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	In-Network rates apply if services provided in connection with emergency medical condition.
	Emergency medical transportation			
	Urgent care			Teladoc Virtual Care visits paid at 100% with no copayment, coinsurance or deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	Out-of-Network coverage available if stay due to emergency medical condition.
	Physician/ surgeon fees		Not covered unless otherwise required by No Surprises Act	

*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
		In-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	15% coinsurance	40% coinsurance unless otherwise required by No Surprises Act	Teladoc Virtual Care visits paid at 100% with no copayment, coinsurance or deductible. 100% coverage if outpatient treatment is the result of a referral from the Medical Review Office of the Employee Assistance Program. No coverage for claims incurred at an Out-of-Network residential treatment facility.
	Inpatient services	Mental/Behavioral: 15% coinsurance Substance Use Disorder: 100% up to $7,500; 20% coinsurance thereafter	Not covered unless otherwise required by No Surprises Act	
If you are pregnant	Office visits	15% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). No coverage for services in connection with a pregnancy of a Dependent child except in limited circumstances when considered preventive under the ACA. Out-of-network coverage available if stay due to emergency medical condition.
	Childbirth/delivery professional services		Not covered unless otherwise required by No Surprises Act	
	Childbirth/delivery facility services			

*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
		In-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	Home health care	15% coinsurance	40% coinsurance	Must be medically necessary, be part of a Physician-established plan, and the Covered Person would have to be hospitalized if the services were not available in his/her home.
	Rehabilitation services		Not covered	Physical Therapy limited to 60 sessions/year then must be medically necessary and prescribed by a Physician. Speech Therapy limited to 20 sessions/year then must be medically necessary and prescribed by a Physician. Limit does not apply to visits for a Mental Health Condition.
	Habilitation services			
	Skilled nursing care			Must be medically necessary, be part of a Physician-established plan, and the Covered Person would have to be hospitalized if the services were not available in his/her home.
	Durable medical equipment		40% coinsurance	Must be certified as medically necessary by the prescribing physician.
	Hospice services	No charge	No charge	Maximum of 210 days.
If your child needs dental or eye care	Children's eye exam	No cost		No limit for Covered Persons under age 19.
	Children's glasses	Frames – no cost Contact Lenses – no cost Lenses – no cost		For Covered Persons under age 19, the Plan will pay up to $130 every two years for frames.
	Children's dental check-up	Delta Dental: 10% coinsurance; Other: 20% coinsurance	40% coinsurance	No Limit for Covered Persons under age 19.

*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
- Cosmetic surgery
- Infertility treatment
- Long-term care (unless needed for acute medical care)
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- 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.)

- Bariatric surgery (must be medically necessary; limited to 1 surgery per lifetime)
- Chiropractic care (up to $50/visit and $600/calendar year)
- Dental care (adult)
- Hearing aids ($2,000 every 5 years)
- 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 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: the Fund Office at 1-816-361-0206 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:

Spanish (Español): Para obtener asistencia en Español, llame al (816) 361-0206.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

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

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** **$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,170**

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

- **The plan's overall deductible** **$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

- **The plan's overall deductible** **$300**
- **Specialist coinsurance** **15%**
- **Hospital (facility) coinsurance** **15%**
- **Other coinsurance** **15%**

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	$300
Copayments	$10
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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