**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 1-866-565-2700 or visit www.655hw.org. 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 1-866-565-2700 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: **$600**/person; **$1,800**/family.<br>Out-of-network: **$700**/person; **$2,100**/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. Preventive care, in-network office visits, dental and vision services, physical, speech or occupational therapy visits, urgent care, and wellness 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. 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?** | Yes. **$250** per person for prescription drugs. 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?** | Medical: In-network: **$2,750**/person; **$6,875** family; Out-of-network: **$5,000**/person; **$12,500**/family.<br>Medical copayment: In-network: **$1,600**/person; **$3,200**/family; Out-of-network: **no limit**.<br>Prescription drugs: In-network: **$3,000**/person; **$5,000**/family; Out-of-network: **no limit**. | 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 limit 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, certain prescription drugs on the PrudentRx Program Drug List, 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.655hw.org or call 1-866-565-2700 for a list of 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 | | 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 | $25 copay/visit; deductible does not apply | 40% coinsurance | None. |
| | Specialist visit | $40 copay/visit; $40 copay/visit + 30% coinsurance for chiropractic office visits; deductible does not apply | 40% coinsurance; $40 copay/visit + 40% coinsurance for chiropractic office visits | Chiropractic office visits limited to 20 visits/year. |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 40% coinsurance | Chiropractic x-rays and labs limited to one set per year. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 40% coinsurance | None. |

| 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 at www.655hw.org. | Generic drugs | Retail: Greater of 15% coinsurance or $10 copay/fill ($50 maximum copay/fill)<br>Mail Order: Greater of 10% coinsurance or $20 copay/fill ($150 maximum copay/fill) | Not covered | Subject to separate deductible or prescription drugs of $250 per person, but no cost sharing for ACA-required generic preventive drugs (or brand drugs if the generic is not medically appropriate).<br>Covers up to a 30-day supply (retail); 31-90 day supply (mail order).<br>You may also fill your maintenance prescriptions (up to a 90-day supply) at all Schnucks and Dierbergs stores that have pharmacies. You must have filled at least one 30-day supply of the prescription at retail before you are eligible to fill the 90-day supply. Mail order copays will apply.<br>Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx Solution program, your deductible and coinsurance will be waived for drugs listed on the PrudentRx Program Drug List. Specialty drugs not on the PrudentRx Program Drug List are payable the same as other preferred brand drugs. Preauthorization of specialty drugs may be required for these drugs to be covered. |
| | Preferred brand drugs | Retail: Greater of 25% coinsurance or $20 copay/fill ($100 maximum copay/fill)<br>Mail Order: Greater of 25% coinsurance or $40 copay/fill ($300 maximum copay/fill)<br>PrudentRx: 30% coinsurance | Not covered | |
| | Non-preferred brand drugs | Retail: Greater of 25% of generic cost or $20 copay/fill + difference between brand name and generic price<br>Mail Order: Greater of 25% of generic cost or $40 copay/fill + difference between brand name and generic price | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 40% coinsurance | Out-of-network free standing surgical centers not covered. |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | Preauthorization is required for Out-of-network outpatient surgery. Failure to preauthorize may result in you paying the full cost of services that are not covered. |

| 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 immediate medical attention** | Emergency room care | 30% coinsurance + $200 copay/visit | 30% coinsurance + $200 copay/visit | Copay waived if admitted. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None. |
| | Urgent care | 30% coinsurance + $75 copay/visit; deductible does not apply | 40% coinsurance + $75 copay/visit; deductible does not apply | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 40% coinsurance | Preauthorization is required for nonemergency admissions. Failure to preauthorize may result in you paying the full cost of services that are not covered. |
| | Physician/surgeon fees | 30% coinsurance | 40% coinsurance | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit and 30% coinsurance for other outpatient services; deductible does not apply | 40% coinsurance | None. |
| | Inpatient services | 30% coinsurance | 40% coinsurance | Preauthorization is required for nonemergency admissions. Failure to preauthorize may result in you paying the full cost of services that are not covered. For Out-of-network providers, you or your provider should obtain preauthorization by calling Behavioral Health Pre-Cert 1-800-292-2879 |
| **If you are pregnant** | Office visits | $25 copay/visit; deductible does not apply | 40% coinsurance | Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Dependent child pregnancy is excluded, except for mandated preventive care services and emergency services. |
| | Childbirth/delivery professional services | 30% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 40% coinsurance | |

| 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** | Home health care | 30% coinsurance | 40% coinsurance | Maximum 40 visits per 12 month period. |
| | Rehabilitation services | 30% coinsurance + $40 copay/visit | 40% coinsurance + $40 copay/visit | Maximum 40 visits per calendar year. Preauthorization is required for rehabilitation admissions. Failure to preauthorize may result in you paying the full cost of services that are not covered. Deductible does not apply to physical, speech or occupational therapy visits. |
| | Habilitation services | 30% coinsurance + $40 copay/visit | 40% coinsurance + $40 copay/visit | Maximum 40 visits (combined with other therapies) per calendar year. |
| | Skilled nursing care | 30% coinsurance | 40% coinsurance | Maximum 60 days per episode. Preauthorization is required. Failure to preauthorize may result in you paying the full cost of services that are not covered. |
| | Durable medical equipment | 30% coinsurance | 40% coinsurance | $1,000 maximum per device. Wigs and prosthesis for hair loss due to a medical diagnosis or treatment covered by the Plan limited to $150 lifetime maximum per person. |
| | Hospice services | 30% coinsurance | 40% coinsurance | Must be terminally ill with a life expectancy of 6 months or less. |
| **If your child needs dental or eye care** | Children's eye exam | $10 copay/visit; deductible does not apply | Not covered | Coverage limited to one exam every year. |
| | Children's glasses | $20 copay/set of lenses; no charge for frames up to $175, then 100% coinsurance with a 20% discount | Not covered | Coverage limited to one pair of lenses every year and one frame every other year. |
| | Children's dental check-up | No charge; deductible does not apply | No charge | Coverage limited to Unit 1 dependents only. Limit of 2 exams and 1 x-ray per year. |

## 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, unless directly related to recovery from an injury or where required by law
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Bariatric surgery (preauthorization is required)
- Chiropractic care (maximum 20 visits/year)
- Dental care (adult) (Unit 1 employees only, maximum $3,000/year)
- Hearing aids (maximum $500/ear every 5 years)
- Infertility treatment (maximum $10,000/lifetime, not covered for dependent child)
- Routine eye care (adult) (limit 1 exam and 1 pair of lenses every year; 1 frame every other year)
- Routine foot care
- Weight loss programs (preauthorization is required, maximum $1,500/lifetime) for non-preventive)

**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 the Department of Labor's Employee Benefits Security Administration is 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 Plan at 1-866-565-2700 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact Missouri Department of Insurance, 301 West High Street, Room 830, Harry S. Truman State Office Building, Jefferson City, MO 56101, 1-800-726-7390, www.insurance.mo.gov.

**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.

*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 | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $600 |
| Copayments | $0 |
| Coinsurance | $1,950 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$2,570** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $120 |
| Copayments | $200 |
| Coinsurance | $1,170 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$1,490** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copayments | $40 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**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 | $600 |
| Copayments | $720 |
| Coinsurance | $480 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,800** |

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