



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, visit [www.d9trusts.org](http://www.d9trusts.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 [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-888-739-6442 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$250/individual or \$750/family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Some <a href="#">preventive care</a> and outpatient surgery services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See your <a href="#">plan</a> document at <a href="http://www.d9trusts.org">www.d9trusts.org</a> for additional information about <a href="#">preventive services</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">Network Providers</a> : \$450 individual / \$1,350 family; for <a href="#">Out-of-Network Providers</a> : \$1,800 individual / \$5,400 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Charges for bariatric surgery, specialty injectables, <a href="#">copayments</a> , <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they do not count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">Network Provider</a> ?	Yes. See <a href="http://www.meritain.com">www.meritain.com</a> or call 1-800-476-9971 for a list of <a href="#">Network Providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">Network Provider</a> . You will pay the most if you use an <a href="#">Out-of-Network Provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">Network Provider</a> may use an <a href="#">Out-of-Network Provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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		
		Network Provider / Network Pharmacy (You will pay the least)	Out-of-Network Provider /Pharmacy (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	None.
	<a href="#">Specialist</a> visit	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	Chiropractic services are limited to 1 visit per day and 50 visits per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No charge.	No charge.	*Not all <a href="#">preventive care</a> is covered; you may have to pay for services that are not <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	None.
	Imaging (CT/PET scans, MRIs)	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> may be required.

\* For more information about limitations and exceptions, see the [plan](#) document at [www.d9trusts.org](http://www.d9trusts.org).

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider / Network Pharmacy (You will pay the least)	Out-of-Network Provider / Pharmacy (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.carelonrx.com">www.carelonrx.com</a></p>	Generic drugs	<p>20% <a href="#">copay</a>, minimum \$8 and maximum \$100 (retail).</p> <p>13.33% <a href="#">copay</a>, minimum \$16 and maximum \$200 (mail order).</p>	20% <a href="#">copay</a> , minimum \$8 and maximum \$100.	<p>Limited to 30-day supply (retail), 90-day supply (Mail Order). <a href="#">Prior authorization</a> required for compound drugs that cost \$375 or more.</p>
	Preferred brand drugs	<p>20% <a href="#">copay</a>, minimum \$20 and maximum \$100 (retail).</p> <p>13.33% <a href="#">copay</a>, minimum \$40 and maximum \$200 (mail order).</p>	20% <a href="#">copay</a> , minimum \$20 and maximum \$100.	
	Non-preferred brand drugs	<p>20% <a href="#">copay</a>, minimum \$35 and maximum \$100 (retail).</p> <p>13.33% <a href="#">copay</a>, minimum \$70 and maximum \$200 (mail order).</p>	20% <a href="#">copay</a> , minimum \$35 and maximum \$100.	
	<a href="#">Specialty drugs</a>	20% <a href="#">copay</a> up to \$100 per month per <a href="#">specialty drug</a> .	20% <a href="#">copay</a> up to \$100 per month per <a href="#">specialty drug</a> .	<p>You will be responsible for paying a 20% <a href="#">copayment</a>, up to a maximum of \$100 per month, for each <a href="#">specialty drug</a>. <a href="#">Specialty drugs</a> have an annual \$2,500 <a href="#">out-of-pocket limit</a> with respect to amounts actually paid by you (not paid by a third party).</p> <p>Certain <a href="#">specialty drugs</a> are offered under the PBM's Specialty Pharmacy Drug Program. If you enroll in the program, you will pay \$0 in <a href="#">coinsurance</a> for <a href="#">specialty drugs</a> offered under the program. If you do not enroll in the program, your <a href="#">coinsurance</a> will be 35% to 45% of the cost of any preferred or non-preferred <a href="#">specialty drugs</a> that are available through the program.</p>

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider / Network Pharmacy (You will pay the least)	Out-of-Network Provider /Pharmacy (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	100% <a href="#">coinsurance</a> above the <a href="#">allowed amount</a> .	<a href="#">Preauthorization</a> may be required.
	Physician/surgeon fees	No charge.	100% <a href="#">coinsurance</a> above the <a href="#">allowed amount</a> .	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 <a href="#">copay, deductible</a> , then 10% <a href="#">coinsurance</a> .	\$75 <a href="#">copay, deductible</a> , then 40% <a href="#">coinsurance</a> .	<a href="#">Copay</a> waived if admitted.  Benefits for Emergency Services provided at an <a href="#">Out-of-Network</a> facility will be paid at the <a href="#">Network cost-sharing</a> level to the extent required by the No Surprises Act.
	<a href="#">Emergency medical transportation</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	Maximum \$30,000 benefit per incident.
	<a href="#">Urgent care</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> is required. Limited to charge for semi-private room.
	Physician/surgeon fees	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> is encouraged. Call Meritain at 1-800-460-6673.
	Inpatient services	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	
If you are pregnant	Office visits	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	None.
	Childbirth/delivery professional services	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	
	Childbirth/delivery facility services	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider / Network Pharmacy (You will pay the least)	Out-of-Network Provider /Pharmacy (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> is required. Limited to maximum payment per visit of no more than the contracted rate between the medical network and the LPN or RN providing the medical service.
	<a href="#">Rehabilitation services</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> is required. Maximum 60 visits/calendar year.
	<a href="#">Habilitation services</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	
	<a href="#">Skilled nursing care</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> is required. See the <a href="#">plan</a> document for more limitations and important information.*
	<a href="#">Durable medical equipment</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	<a href="#">Preauthorization</a> may be required.
	<a href="#">Hospice services</a>	After <a href="#">deductible</a> , 10% <a href="#">coinsurance</a> .	After <a href="#">deductible</a> , 40% <a href="#">coinsurance</a> .	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	None.
	Children's glasses	Not covered.	Not covered.	None.
	Children's dental check-up	Not covered.		

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery, except for treatment or surgery due solely to an accidental injury or birth defect, provided treatment is undertaken as soon as medically feasible</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (Adult)</li> <li>Gene Therapy Treatments</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight loss programs</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) document at [www.d9trusts.org](http://www.d9trusts.org).

**Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your [plan](#) document.)**

- Bariatric surgery, subject to the [plan](#) requirements for coverage
- Chiropractic care, subject to [deductible](#) and [coinsurance](#), limited to one visit/day, 50 visits/year
- Hearing aids limited to 1 hearing aid per ear and \$2,000 maximum for both ears per five-year period
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care, if service is by a Podiatrist

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** If you have a complaint or are dissatisfied with a denial of coverage for [claims](#) under your [plan](#), you may be able to [appeal](#) or file a [grievance](#). For questions about your rights, this notice, or assistance, you can contact: Joint Board of Trustees of the District No. 9, IAMAW Welfare Trust Fund, 12365 St. Charles Rock Rd., Bridgeton, Missouri 63044, 1-314-739-6442, 1-888-739-6442.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Missouri Department of Insurance, 301 W. High Street, Room 830, Harry S. Truman State Office Building, Jefferson City, MO 65101, 1-800-726-7390, or visit the website at [www.insurance.mo.gov](http://www.insurance.mo.gov), or email [consumeraffairs@insurance.mo.gov](mailto:consumeraffairs@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](#).

**Language Access Services:**

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-739-6442.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-739-6442.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-739-6442.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-739-6442.

—————*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](#) \$250
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$510</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 10%
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$250
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$470</b>

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

- The [plan's](#) overall [deductible](#) \$250
- [Specialist coinsurance](#) 10%
- Hospital (facility) [copayments](#) \$75
- Other [coinsurance](#) 10%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$225
<a href="#">Copayments</a>	\$75
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$400</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered Services