**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. 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 1-888-739-6442 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For Network Providers: $250/individual or $750/family; for Out-of-Network Providers: $750/individual or $1,500/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. Some preventive care is 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 your plan document at www.d9trusts.org for additional information about preventive services. |
| **Are there other deductibles for specific services?** | Yes. Dental: $100 per individual, except for preventive services. 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?** | For Network Providers: $2,250 individual / $4,500 family; for Out-of-Network Providers: $9,000 individual / $18,000 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?** | Charges for bariatric surgery, specialty injectables, copayments, premiums, balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they do not count toward the out–of–pocket limit. |
| **Will you pay less if you use a Network Provider?** | Yes. See www.meritain.com or call 1-800-476-9971 for a list of Network Providers. | This plan uses a provider network. You will pay less if you use a Network Provider. 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 may 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 | | |
|---|---|---|---|---|
| | | 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 provider's office or clinic** | Primary care visit to treat an injury or illness | $15/visit copayment, deductible, then 15% coinsurance. | $15/visit copayment, deductible, then 45% coinsurance. | None. |
| | Specialist visit | $25/visit copayment, deductible, then 15% coinsurance. | $25/visit copayment, deductible, then 45% coinsurance. | Chiropractic services are limited to 1 visit per day and 30 visits per calendar year. |
| | Preventive care/screening/ immunization | No charge. | No charge. | *Not all preventive care is covered; you may have to pay for services that are not 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) | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | None. |
| | Imaging (CT/PET scans, MRIs) | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization may be required. |

* For more information about limitations and exceptions, see the plan document at 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 |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.carelonrx.com | Generic drugs | 20% copay, minimum $8 and maximum $100 (retail). 13.33% copay, minimum $16 and maximum $200 (mail order). | 20% copay, minimum $8 and maximum $100. | Limited to 30-day supply (retail), 90-day supply (Mail Order). Prior authorization required for compound drugs that cost $375 or more. |
| | Preferred brand drugs | 20% copay, minimum $20 and maximum $100 (retail). 13.33% copay, minimum $40 and maximum $200 (mail order). | 20% copay, minimum $20 and maximum $100. | |
| | Non-preferred brand drugs | 20% copay, minimum $35 and maximum $100 (retail). 13.33% copay, minimum $70 and maximum $200 (mail order). | 20% copay, minimum $35 and maximum $100. | |
| | Brand where generic is available. | 50% copayment. | 50% copayment. | |
| | Specialty drugs | 20% copay up to $150 per month per specialty drug. | 20% copay up to $150 per month per specialty drug. | You will be responsible for paying a 20% copayment, up to a maximum of $150 per month, for each specialty drug. Specialty drugs have an annual $3,250 out-of-pocket limit with respect to amounts actually paid by you (not paid by a third party).<br>Certain specialty drugs are offered under the PBM's Specialty Pharmacy Drug Program. If you enroll in the program, you will pay $0 in coinsurance for specialty drugs offered under the program. If you do not enroll in the program, your coinsurance will be 35% to 45% of the cost of any preferred or non-preferred specialty drugs that are available through the program. |

| 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) | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization may be required. |
| | Physician/surgeon fees | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | |
| **If you need immediate medical attention** | Emergency room care | $100 copay, deductible, then 15% coinsurance. | $100 copay, deductible, then 45% coinsurance. | Copay waived if admitted.<br><br>Benefits for Emergency Services provided at an Out-of-Network facility will be paid at the Network cost-sharing level to the extent required by the No Surprises Act. |
| | Emergency medical transportation | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Maximum $30,000 benefit per incident.<br><br>Air Ambulance services will be paid at the Network cost-sharing level. |
| | Urgent care | $50 copay, deductible, then 15% coinsurance. | $50 copay, deductible, then 45% coinsurance. | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization is required. Limited to charge for semi-private room. |
| | Physician/surgeon fees | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization is encouraged. Call Meritain at 1-800-460-6673. |
| | Inpatient services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | |
| **If you are pregnant** | Office visits | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | None. |
| | Childbirth/delivery | After deductible, 15% | After deductible, 45% coinsurance. | |

| 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 |
| | professional services | coinsurance. | | |
| | Childbirth/delivery facility services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | |
| **If you need help recovering or have other special health needs** | Home health care | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization 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. |
| | Rehabilitation services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization is required. Maximum 60 visits/calendar year. |
| | Habilitation services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | |
| | Skilled nursing care | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization is required. See the plan document for more limitations and important information.* |
| | Durable medical equipment | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | Preauthorization may be required. |
| | Hospice services | After deductible, 15% coinsurance. | After deductible, 45% coinsurance. | |
| **If your child needs dental or eye care** | Children's eye exam | No charge. | No charge first $36, then 100% coinsurance. | Limited to 1 exam per 12 months. |
| | Children's glasses | No charge first $175, then 100% coinsurance for frames; no charge for lenses. | Frames: no charge first $45, then 100% coinsurance; Lenses: no charge first $28 single vision, $45 lined bifocal, $56 lined trifocal, $80 | Limited to one frame per 24 months and one pair of lenses per 12 months. |

* For more information about limitations and exceptions, see the plan document at 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 |
| | | | lenticular. 100% coinsurance above these amounts. | |
| | Children's dental check-up | Limited to 2 each on exams, cleanings, bitewings, fluoride, and periodontal cleanings and 1 full mouth x-ray per calendar year; 1 panoramic x-ray per 36 months. | | |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)**

- Acupuncture
- 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
- Gene Therapy Treatments
- Long-term care
- Weight loss programs

**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, 30 visits/year
- Dental care (Adult), limited to 2 regular exams, 2 cleanings, 2 bitewings, 2 periodontal cleanings, and 1 full mouth x-ray/calendar year; 1 panoramic x-ray/36 months; and maximum benefit of $2,500/calendar 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 eye care (Adult), limited to one exam/12 months
- 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. 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:** 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. 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, or email 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, kwiijigo 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 copayment | $25 |
| 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 | $250 |
| Copayments | $30 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,840** |

### 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 copayment | $25 |
| 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 | $250 |
| Copayments | $200 |
| Coinsurance | $800 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,270** |

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

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist copayment | $25 |
| Hospital (facility) copayments | $100 |
| 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 | $250 |
| Copayments | $180 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$730** |

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