

The information here is a summary of the provisions of the official documents that govern the operation of the Pension and Welfare Plans and the benefits provided by the Pension and Welfare Plans. Those official documents include the Trust Agreements, the Summary Plan Descriptions, the Summaries of Material Modifications that are published in the newsletter and other written policies, rules and guidelines. While we have attempted to insure that the information is as accurate as possible, in the event there is any conflict in the official documents, the terms of the official documents will control. As always, if you have any questions regarding the operation of the Plans or about your benefits, please feel free to call the Fund Office at (314) 739-6442.

**Notes:**

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

**District No. 9, I. A. M. & A. W. Welfare Trust**  
**12365 St Charles Rock Road**  
**Bridgeton, MO 63044**  
**314-739-6442**

C3G Plan	
<b>Annual Deductible</b>	
Individual	
HMO	\$250
PPO	\$250
Non-Network	\$250
<b>Family</b>	
HMO	\$750
PPO	\$750
Non-Network	\$750
	Deductibles not applied to annual out-of-pocket max

Out-of-Pocket Maximums	
Individual	
HMO	\$250
PPO	\$500
Non-Network	\$1,000
<b>Family</b>	
HMO	\$750
PPO	\$1,500
Non-Network	\$3,000

Benefit Maximums	
Lifetime	\$1,000,000 (+\$100,000 per year restoration)
<b>Death Benefit</b>	
Employee	\$20,000
Spouse	\$2,000
Dependent Child (after 10th day)	\$2,000
Dependent Child (live birth to 10th day)	\$100

Accidental Death, Disability and loss of sight	
Employee	\$20,000

Weekly Short Term Disability	
Maximum benefit period	26 weeks
Benefit waiting period	Benefits begin on 8 <sup>th</sup> day of disability for illness & 1 <sup>st</sup> day for accident
Benefit amount	70% of weekly earnings will be paid to a maximum of \$400 per week

C3G Plan	
<b>Doctor Office Visit</b>	
Primary Care Physician	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
<b>Specialty Care</b>	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%

C3G Plan	
<b>Mental Disorders/Substance Abuse</b>	
	After Deductible
In-Network	90%
Non-Network	60%
Maximum inpatient days per calendar year	30 days
Maximum residential days per calendar year	15 days
Maximum outpatient visits per calendar year	50 visits
Lifetime Limit for Substance Abuse	3 inpatient and 3 residential admissions

St. Johns Mercy Managed Behavioral Health (Formally known as Unity Managed Mental Health) must be notified prior to seeking treatment for any mental or nervous disorder or any drug or alcohol problem. Please contact them at: (314) 729-4600 in St Louis, MO or 1-800-413-8008 (Toll-Free)

C3G Plan	
<b>Surgeon and Physician Services</b>	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
<b>Outpatient Surgery</b>	
Under 23 hour stay	No Deductible
HMO	100%
PPO	100%
Non-Network	100%

C3G Plan	
<b>Hospital Services</b>	
Room and Board	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
Maximum number of days	No Limit
Healthlink should be notified prior to any Inpatient Admissions, Ambulatory Service, Outpatient Surgery, Home Health Care, Durable Medical Equipment, and Rehab and Outpatient Physical Therapy. Please have admitting physician or member call <b>HealthLink at: 1-877-284-0102 (Toll-Free Nationwide)</b>	

C3G Plan	
<b>Surgeon and Physician Services</b>	
Diagnostic X-Ray and Lab	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%

C3G Plan	
<b>Emergency Room</b>	
	\$75 Copay, then Deductible, then the Plan Pays:
HMO	90%
PPO	80%
Non-Network	60%

C3G Plan	
<b>Urgent Care Center</b>	
	After Deductible, then the Plan Pays:
HMO	90%
PPO	80%
Non-Network	60%

	C3G Plan
Specialty Drugs provided through PBM	
	No Deductible
	Member pays 20% up to \$100; Member out of pocket is limited to \$2,500 annually
	Chemotherapy drugs not subject to deductible or copay

Ambulance Service	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%

Transplants	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
Lifetime Maximum Benefit per Procedure	\$125,000
Transplant Donor Expenses	Secondary to donor's coverage

Spinal Manipulation Chiropractic	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
Benefit Limits	50 visits per calendar year
Maximum benefit per calendar year	\$2,000

Speech Therapy	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
	Covered as Restorative Only

Physical Therapy	
	After Deductible
Benefit Limits	\$2,500 per 12 month period per condition
HMO	90%
PPO	80%
Non-Network	60%

	C3G Plan
Well Woman/Well Man	
Mammogram	
	After Deductible
HMO	90%
PPO	80%
Non-Network	60%
Benefit Limits	1 per calendar year
Pap smears/Prostate Exams (PSA)	
	No Deductible
Visit in connection	Covered
HMO	100%
PPO	100%
Non-Network	100%

Childhood Immunizations	
Through age 12	No Deductible
Visit in connection	Covered
HMO	100%
PPO	100%
Non-Network	100%

Prescription Drug Benefit	
Retail Pharmacy	
Generic Drug Copay	20% of cost, min. of \$8 and max. of \$100
Formulary Brand Name Drug Copay	20% of cost, min. of \$20 and max. of \$100
Non-Formulary Brand Name Drug Copay	20% of cost, min. of \$35 and max. of \$100
Mail Order (90 Day Supply)	
Generic Drug Copay	13.33% of cost, min. of \$16 and max. of \$200
Formulary Brand Name Drug Copay	13.33% of cost, min. of \$40 and max. of \$200
Non-Formulary Brand Name Drug Copay	13.33% of cost, min. of \$70 and max. of \$200

Accidental Injuries Benefit	
	No annual deductible or co-insurance applies to covered charges incurred for treatment of an accidental injury that is provided during the 48 hours following the accident. Appropriate copay's apply.

C3G Plan	
<b>Vision Care Benefits</b>	
Eye exam per person, in calendar year	
In-Network	100%
Non-Network	Up to \$36
Eyeglass lenses, per pair, in calendar year	
Single Vision	
In-Network	100%
Non-Network	Up to \$28
Lined Bifocal	
In-Network	100%
Non-Network	Up to \$45
Lined Trifocal	
In-Network	100%
Non-Network	Up to \$56
Eyeglass Frames	
Benefit Limits	1 every 24 months
In-Network	Up to \$120
Non-Network	Up to \$45
Contact Lenses	
Benefit Limits	1 every 12 months
In-Network	Up to \$120
Non-Network	Up to \$105

Core Dental Benefits	
Calendar Year Deductible	
Individual	\$25
Family	Not Limited
Routine Preventive	No Deductible, 100%
Basic Restorative	After Deductible, 80%
Major Dental	After Deductible, 80%
Maximum Annual Benefit	\$1,500