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/.com or call 1-888-739-6442 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250/individual or $750/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 and outpatient surgery services 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 your policy or plan document at www.d9trusts.org for additional information about preventive services.
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?	For network providers: HMO $250 individual / $750 family and PPO $500 individual / $1,500 family; for out-of-network providers $1,000 individual / $3,000 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 don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthlink.com or call 1-888-739-6442 for a list of network providers.	You pay the least if you use an HMO Provider. You pay more if you use a PPO 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 HMO or PPO 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			Limitations, Exceptions, & Other Important Information
		HMO Network Provider / Network Pharmacy (You will pay the least)	PPO Network Provider /Mail Order Pharmacy (You will pay more)	Out-of-Network Provider/Pharmacy (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	After deductible 10% coinsurance	After deductible 20% coinsurance	After deductible 40% coinsurance	None
	Specialist visit	After deductible 10% coinsurance	After deductible 20% coinsurance	After deductible 40% coinsurance	Chiropractic services are limited to 1 visit per day and 50 visits per calendar year.
	Preventive care/screening/ immunization	No charge	No charge	No charge	*Not all preventive care is covered; refer to pages 38-40 of your SPD. 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)	After deductible 10% coinsurance	After deductible 20% coinsurance	After deductible 40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	After deductible 10% coinsurance	After deductible 20% coinsurance	After deductible 40% coinsurance	Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.d9trusts.org.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HMO Network Provider / Network Pharmacy (You will pay the least)	PPO Network Provider /Mail Order Pharmacy (You will pay more)	Out-of-Network Provider/Pharmacy (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.ldirx.com	Generic drugs	20% copay, minimum $8 and maximum $100	13.33% copay, minimum $16 and maximum $200	20% copay, minimum $8 and maximum $100	Limited to 30 day supply (retail), 90 day supply (Mail Order). Mandatory Mail Order for maintenance drugs following two consecutive 30-day prescriptions. Prior authorization required for compound drugs.
	Preferred brand drugs	20% copay, minimum $20 and maximum $100	13.33% copay, minimum $40 and maximum $200	20% copay, minimum $20 and maximum $100	
	Non-preferred brand drugs	20% copay, minimum $35 and maximum $100	13.33% copay, minimum $70 and maximum $200	20% copay, minimum $35 and maximum $100	
	Specialty drugs	20% copay up to $100 per month per specialty drug	20% copay up to $100 per month per specialty drug	20% copay up to $100 per month per specialty drug	After $500,000 in benefits, copay increases to 50% and monthly out of pocket limits do not apply. Cancer drugs not subject to copay. Specialty injectables have a $2,500 out of pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	100% coinsurance above the allowed amount	Preauthorization may be required.
	Physician/surgeon fees	No charge	No charge	100% coinsurance above the allowed amount	
If you need immediate medical attention	Emergency room care	$75 copay, deductible then 10% coinsurance	$75 copay, deductible then 20% coinsurance	$75 copay, deductible then 40% coinsurance	Copay waived if admitted.
	Emergency medical transportation	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Maximum $30,000 benefit per incident.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HMO Network Provider / Network Pharmacy (You will pay the least)	PPO Network Provider /Mail Order Pharmacy (You will pay more)	Out-of-Network Provider/Pharmacy (You will pay the most)	
	Urgent care	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required. Limited to charge for semi-private room.
	Physician/surgeon fees	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required. Call Healthlink at 1-877-284-0102.
	Inpatient services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	
If you are pregnant	Office visits	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Coverage limited to employee and employee's spouse only.
	Childbirth/delivery professional services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	
	Childbirth/delivery facility services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	
If you need help recovering or have other special health needs	Home health care	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required. Limited to maximum of $40/visit.
	Rehabilitation services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required. Maximum 60 visits/calendar year.
	Habilitation services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HMO Network Provider / Network Pharmacy (You will pay the least)	PPO Network Provider /Mail Order Pharmacy (You will pay more)	Out-of-Network Provider/Pharmacy (You will pay the most)	
	Skilled nursing care	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required. See the SPD for more limitations and important information.*
	Durable medical equipment	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization may be required.
	Hospice services	After deductible, 10% coinsurance	After deductible, 20% coinsurance	After deductible, 40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered			None

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, except for treatment or surgery due solely to an accidental injury or birth defect, provided treatment is undertaken as soon as medically feasible
- Dental care (Adult)
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

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

- Bariatric surgery, subject to the plan requirements for coverage (see pages 45-46 of your SPD)
- 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

* For more information about limitations and exceptions, see the plan or policy document at www.d9trusts.org.

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**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 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*)

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$30
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$640**

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*)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$1,000
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,570**

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*)

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$80
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$360**

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

ADDENDUM

Section 1557 Nondiscrimination Notice

The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters, and
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters, and
  - Information written in other languages.

If you need these services, please contact:

David DeJarnett, Director of Operations
12365 St. Charles Rock Rd.
Bridgeton, Missouri 63044
Phone: 314-739-6442
Fax: 314-298-3409
ddejarnett@d9trusts.org

If you believe that the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

David DeJarnett, Director of Operations
12365 St. Charles Rock Rd.
Bridgeton, Missouri 63044
Phone: 314-739-6442
Fax: 314-298-3409
ddejarnett@d9trusts.org

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Director of Operations David DeJarnett is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537 7697(TDD).Complaint forms are available at: *http://www.hhs.gov/ocr/office/file/index.html*.

Section 1557 Required Language Taglines

- (English) ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-314-739-6442
- (Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-314-739-6442
- (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-314-739-6442
- (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-314-739-6442
- (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-314-739-6442
- (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-314-739-6442
- (Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-314-739-6442
- (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-314-739-6442 번으로 전화해 주십시오.
- (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-314-739-6442
- (Arabic) 1-314-739-6442- ملحوظة: إذا تحدث كنت تتوافر الالغوية المساعدة خدمات فإن الالغة، اذكر تالمجان لك تصل بالرقم اتصل
- (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-314-739-6442
- (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-314-739-6442
- (Pennsylvania Dutch) Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-314-739-6442
- (Hindi) □□□□□ द□: य□द आप□□□ □□□□□ ह□□□ □□□□ □□□ □□□□□ म□ □□□□ □□□□□□ □□□□□□ □□□□□□ ह। □ 1-314-739-6442 पर □□□ कर□।
- (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-314-739-6442）まで、お電話にてご連絡ください。
- (Persian) ت□جه: اگر شما به زبان فارسی صحبت می‌کنید، خدمات تسهیلات زبانی به صورت رایگان در دسترس شما می‌باشد. با 1-314-739-6442 تماس بگیرید.
- (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-314-739-6442
- (Gujarathi) □□□□□: □□ □□□ □□□□□□ □□□□□ □□, □□ □□:□□□□□ □□□□ □□□□ □□□□□ □□□□□ □□□□ □□□□□□ ૬. □□□ □□□ 1-314-739-6442
- (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-314-739-6442
- (Dutch) AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-314-739-6442