
 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 ?	\$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 plan document at www.d9trusts.org for additional information about preventive services .
Are there other deductibles for specific services?	Yes. Dental: \$25 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 : \$250 individual / \$750 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 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	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	None.
	Specialist visit	After deductible , 10% 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.	*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 , 10% coinsurance .	After deductible , 40% coinsurance .	None.
	Imaging (CT/PET scans, MRIs)	After deductible , 10% coinsurance .	After deductible , 40% 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
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scrips.com</p>	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). Mandatory Mail Order for maintenance drugs following two consecutive 30-day prescriptions . 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.	
	Specialty drugs	20% copay up to \$100 per month per specialty drug .	20% copay up to \$100 per month per specialty drug .	You will be responsible for paying a 20% copayment , up to a maximum of \$100 per month, for each specialty drug . Specialty drugs that are Essential Health Benefits have an annual \$2,500 out-of-pocket limit with respect to amounts actually paid by you (not paid by a third party). If you enroll in the SaveonSP program, you will pay \$0 in coinsurance for specialty drugs that are not Essential Health Benefits. If you are not enrolled in the SaveonSP program, your coinsurance will be 30% for specialty drugs that are not Essential Health Benefits.

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% coinsurance above the allowed amount .	Preauthorization may be required.
	Physician/surgeon fees	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 40% coinsurance .	Copay waived if admitted. 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. Maximum \$30,000 benefit per incident.
	Emergency medical transportation	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Air Ambulance services will be paid at the Network cost-sharing level.
	Urgent care	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Preauthorization is required. Limited to charge for semi-private room.
	Physician/surgeon fees	After deductible , 10% 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 , 40% coinsurance .	Preauthorization is encouraged. Call Meritain at 1-800-460-6673.
	Inpatient services	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	
If you are pregnant	Office visits	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	None.
	Childbirth/delivery professional services	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	
	Childbirth/delivery facility services	After deductible , 10% coinsurance .	After deductible , 40% 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
If you need help recovering or have other special health needs	Home health care	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Preauthorization is required. Limited to maximum of \$40/visit.
	Rehabilitation services	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Preauthorization is required. Maximum 60 visits/calendar year.
	Habilitation services	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	
	Skilled nursing care	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Preauthorization is required. See the plan document for more limitations and important information.*
	Durable medical equipment	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	Preauthorization may be required.
	Hospice services	After deductible , 10% coinsurance .	After deductible , 40% coinsurance .	
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	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 .)	
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Long-term care Routine eye care (Adult) Weight loss programs

* For more information about limitations and exceptions, see the [plan](#) document at 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
- 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 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 other 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$310

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$0
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$270

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$250

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