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.stllaborers.com. 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 1-800-489-0228 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1 and Tier 2 providers $400 individual/ $800 family, for Tier 3 Out-of-Network providers $500 individual/ $1,000 family. Co-pays, dental benefits, and prescription drug benefits do not count toward the deductible.	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. Preventive services provided by Tier 1 and Tier 2 providers 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, as well as tobacco cessation services. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Dental: $75 individual/ $225 family. Weight loss programs: $100. 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 Tier 1 and Tier 2 providers $4,000 individual/ $5,000 family. For Tier 3 Out-Of-Network providers: no limit. For prescription drugs in-network, $2,600 individual/ $8,200 family. For prescription drugs out-of-network: no limit.	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 dental and vision expenses, premiums, balance-billing charges, the difference in cost between generic and multi-source prescription drugs, and	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

	health care this plan doesn't cover.	
Will you pay less if you use a network provider?	Yes. See www.chcmo.com or call 1-800-755-3901 for a list of Tier 1 and Tier 2 network providers.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use a Tier 3 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 Tier 1 or Tier 2 provider may use a Tier 3 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 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
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Out-of-Network Provider (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	$15 co-pay, then deductible; Other services provided in office setting: 10% coinsurance after deductible.	$15 co-pay, then deductible; Other services provided in office setting: 20% coinsurance after deductible.	40% coinsurance after deductible; Other services in office setting: 40% coinsurance after deductible	None
	Specialist visit	$15 co-pay, then deductible; Other services provided in office setting: 10% coinsurance after deductible.	$15 co-pay, then deductible; Other services provided in office setting: 20% coinsurance after deductible.	40% coinsurance after deductible; Other services in office setting: 40% coinsurance after deductible	Maximum of 60 chiropractor visits/year, including 26 Out-of-Network. Out-of-Network chiropractor limited to spinal manipulation and manual medical intervention services.
	Preventive care/screening/ immunization	No charge	No charge	40% coinsurance after deductible	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)	10% coinsurance after deductible.	20% coinsurance after deductible.	40% coinsurance after deductible.	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible.	20% coinsurance after deductible.	40% coinsurance after deductible.	Preauthorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optum.com/mycatamaranrx	Generic drugs	$5 co-pay (retail); $12.50 co-pay (mail/ 90 day retail).	$5 co-pay (retail); $12.50 co-pay (mail/ 90 day retail).	Not covered	Limited to 30-day supply (retail) or a 90-day supply (mail order or Retail 90). No cost-sharing for PPACA preventive care drugs (may be limited to generic). NSAIDS, Celebrex, Antihyperlipidemics, and Peptic Ulcer Therapies require trial of generic. No coverage for compound bulk chemicals and medicines. Preauthorization required for compound drug prescriptions in excess of $250. Additional clinical guidelines may apply.
	Single Source brand name drugs (brand name where no generic is available)	$25 co-pay (retail); $62.50 co-pay (mail/ 90 day retail).	$25 co-pay (retail); $62.50 co-pay (mail/ 90 day retail).	Not covered	
	Multi-Source brand name drugs (brand name where generic equivalent is available)	$5 co-pay + difference in cost between brand name and generic (retail); $12.50 co-pay + difference in cost between brand name and generic (mail/ 90 day retail).	$5 co-pay + difference in cost between brand name and generic (retail); $12.50 co-pay + difference in cost between brand name and generic (mail/ 90 day retail).	Not covered	
	Specialty drugs	Covered under applicable physician or medical facility benefit or prescription drug category.	Covered under applicable physician or medical facility benefit or prescription drug category.	Covered under applicable physician or medical facility benefit. Not covered under prescription benefit.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance for hospital after deductible	Preauthorization required. Ambulatory surgery center not covered for Tier 3 Out-of-Network.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	None.
If you need immediate medical attention	Emergency room care	$75 co-pay + 10% coinsurance after deductible	$75 co-pay + 20% coinsurance after deductible	$75 co-pay + 20% coinsurance after deductible	None
	Emergency medical transportation	10% coinsurance after deductible	20% coinsurance after deductible	Coinsurance after deductible, based on the facility to which the individual is transported (Tier 1: 10%; Tier 2: 20%; Tier 3 Out-of-Network: 40%)	None
	Urgent care	$15 co-pay + 10% coinsurance after deductible	$15 co-pay + 20% coinsurance after deductible	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 co-pay/day (maximum of $500) + 10% coinsurance after deductible	$100 co-pay/day (maximum of $500) + 20% coinsurance after deductible	40% co-insurance after deductible	Preauthorization required. Limited to charge for semi-private room.
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $15 co-pay, then deductible Other outpatient services: 10% coinsurance after deductible	Office Visit: $15 co-pay, then deductible Other outpatient services: 20% coinsurance after deductible	Office Visit: 40% coinsurance after deductible Other outpatient services: 40% coinsurance after deductible	None
	Inpatient services	$100 co-pay/day (maximum of $500) + 10% coinsurance after deductible	$100 co-pay/day (maximum of $500) + 20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required
If you are pregnant	Office visits	$15 co-pay, then deductible; Other services provided in office setting: 10% coinsurance after deductible.	$15 co-pay, then deductible; Other services provided in office setting: 20% coinsurance after deductible.	40% coinsurance after deductible; Other services in office setting: 40% coinsurance after deductible	Preauthorization required. No charge for prenatal preventive care from Tier 1 and Tier 2 providers. No coverage for dependent child's pregnancy or newborn, unless part of the customary global physician package for prenatal care. No out-of-network coverage for dependent child's pregnancy. No coverage for non-routine prenatal care of dependent child. No coverage for dependent pregnancy complications.
	Childbirth/delivery professional services	No charge for delivery related physician care (if included in global package). $100 co-pay/day (maximum of $500) + 10% coinsurance after deductible for other services and hospital facility charges.	No charge for delivery related physician care (if included in global package). $100 co-pay/day (maximum of $500) + 20% coinsurance after deductible for other services and hospital facility charges.	40% coinsurance after deductible	
	Childbirth/delivery facility services				
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required. Maximum of 100 visits/ year.
	Rehabilitation services	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required. Tier 3 Out-of- Network maximum of 30 visits/ year

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider (You will pay more)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Habilitation services	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required.
	Skilled nursing care	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required. Maximum 90 days/ year
	Durable medical equipment	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Co-pay, Deductible and Coinsurance do not apply to items provided by a Tier 1 or Tier 2 provider and determined to be preventive care.
	Hospice services	10% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible	Only covered when individual has six months or less to live. Maximum of 15 bereavement counseling visits/year.
If your child needs dental or eye care	Children's eye exam	$10 co-pay		100% coinsurance after the first $38	There is only one vision network. Limited to 1 exam/ year.
	Children's glasses	$20 co-pay for lenses. 100% coinsurance after the first $180 for frames after 20% discount from network provider.		100% coinsurance after the first $50 (single vision), $65 (bifocal), $100 (trifocal), $110 (lenticular). 100% coinsurance after the first $50 (frames).	There is only one vision network. Maximum of 1 pair of lenses and 1 frame/ year.
	Children's dental check-up	No charge		No charge if the charge is equal to or less than the maximum plan allowance for a network dentist.	Maximum of 2 check-ups/year.

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.)

- Bariatric surgery
- Cosmetic surgery except when due solely to an accidental injury or solely to a birth defect, provided such treatment is undertaken as soon as it is medically feasible
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Facilities outside of a 250-mile radius. See section 6.D of the SPD for further explanation.

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

- Acupuncture, by a licensed acupuncturist or licensed chiropractor
- Chiropractic care, maximum of 60 visits per calendar year for Tier 1, Tier 2 and Out-of-Network combined; only 26 of those visits can be Out-of-Network.
- Dental care (Adult)
- Habilitation services
- Hearing aids, subject to $25 co-pay/device. Maximum benefit of $1,500 per hearing aid and one hearing aid per ear in a 48 month period. Hearing aids for newborns exempt from 48 month limit.
- Private duty nursing by an RN or LPN if patient is confined as a bed patient in a hospital
- Routine eye care (adult)
- Routine foot care
- Weight loss programs, if medically necessary and under medical supervision, maximum lifetime benefit of $1,500. Obesity screening provided with no charge to participant for Tier 1 or Tier 2 providers

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: Greater St. Louis Construction Laborers' Welfare Fund, 2357 59th Street, St. Louis, MO 63110, 1-800-489-0228, or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272).

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	$400
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$250
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,710

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

The plan's overall deductible	$400
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$630
Coinsurance	$190
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,280

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

The plan's overall deductible	$400
Specialist coinsurance	10%
Hospital (facility) copayments	10%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$105
Coinsurance	$125
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$630

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

ADDENDUM

Section 1557 Nondiscrimination Notice

The Greater St. Louis Construction Laborers' Welfare Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Greater St. Louis Construction Laborers' Welfare Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Greater St. Louis Construction Laborers' Welfare Fund:

- 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:

Diana Marburger
Welfare Director
2357 59th St., St. Louis. Missouri 63110
Phone: (314) 646-4430
Fax: (314) 644-6391
dlm@stllaborers.com

If you believe that the Greater St. Louis Construction Laborers' Welfare Fund 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:

Diana Marburger
Welfare Director
2357 59th St., St. Louis. Missouri 63110
Phone: (314) 646-4430
Fax: (314) 644-6391
dlm@stllaborers.com

You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Welfare Director Diana Marburger 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, 1–800–368–1019, 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 1-314-646-4430
- (Spanish) ATENCIÓN: si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-314-646-4430
- (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-314-646-4430
- (French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-314-646-4430
- (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 1-314-646-4430
- (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-314-646-4430
- (Serbo-Croatian) OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-314-646-4430
- (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-314-646-4430 번으로 전화해 주십시오.
- (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-314-646-4430
- (Arabic) 1-314-646-4430- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
- (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-314-646-4430
- (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-314-646-4430
- (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 1-314-646-4430
- (Hindi) ध्यान द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-314-646-4430 पर कॉल 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。1-314-646-4430 まで、お電話にてご連絡ください。
- Persian توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-314-646-4430 فراهم می باشد. با تماس بگیرید.