



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](http://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](http://www.healthcare.gov/sbc-glossary.com) or call 1-800-489-0228 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	For Tier 1 <u>providers</u> \$400 individual/ \$800 family, for Tier 2 <u>Out-of-Network providers</u> \$500 individual/ \$1,000 family. <u>Co-pays</u> , dental benefits, and <u>prescription drug</u> benefits do not count toward the <u>deductible</u> .	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive services</u> provided by Tier 1 <u>providers</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> , as well as tobacco cessation service. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. Dental: \$75 individual/ \$225 family. Weight loss programs: \$100. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	For Tier 1 <u>providers</u> \$4,000 individual/ \$5,000 family. For Tier 2 <u>Out-Of-Network providers</u> : no limit. For <u>prescription drugs in-network</u> , \$2,600 individual/ \$8,200 family. For <u>prescription drugs out-of-network</u> : no limit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	Charges for dental and vision expenses, <u>premiums</u> , <u>balance-billing</u> charges, the difference in cost between generic and multi-source <u>prescription drugs</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. Visit <a href="http://www.aetna.com/individuals-families/find-a-doctor.html">www.aetna.com/individuals-families/find-a-doctor.html</a> Ext. 2 for a list of Tier 1 <u>network providers</u> .	You pay the least if you use a <u>provider</u> in Tier 1. You will pay the most if you use a Tier 2 <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your Tier 1 <u>provider</u> may use a Tier 2 <u>Out-of-Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care <u>provider's</u> office or clinic</b>	<u>Primary care</u> visit to treat an injury or illness	\$15 <u>co-pay</u> , then <u>deductible</u> ; Other services provided in office setting: 10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> ; Other services provided in office setting: 40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	\$15 <u>co-pay</u> , then <u>deductible</u> ; Other services provided in office setting: 10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> ; Other services provided in office setting: 40% <u>coinsurance</u> after <u>deductible</u>	Maximum of 60 chiropractor visits/year, including 26 <u>Out-of-Network</u> . <u>Out-of-Network</u> chiropractic services are limited to only spinal manipulation and manual medical intervention services.
	<u>Preventive care/screening/immunization</u>	No charge.	40% <u>coinsurance</u> after <u>deductible</u> .	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required.

Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>	Generic drugs	\$5 <u>co-pay</u> (retail); \$12.50 <u>co-pay</u> (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 <u>preventive</u> care drugs (may be limited to generic). NSAIDS, Celebrex, Antihyperlipidemics (cholesterol lowering agents), and Peptic Ulcer Therapies require trial of generic. No coverage for compound bulk chemicals and medicines. <u>Preauthorization</u> required for compound drug <u>prescriptions</u> in excess of \$250. Additional clinical guidelines may apply. Generic medications should be dispensed when available. If you purchase a brand name drug or high cost generic when a lower cost generic drug is available, you could be responsible for the generic Co-pay plus the difference between the brand or higher cost generic drug and the lower costing generic drug.
	Single Source brand name drugs (brand name where no generic is available)	\$25 <u>co-pay</u> (retail); \$62.50 <u>co-pay</u> (mail/ 90-day retail).	Not covered.	
	Multi-Source brand name drugs (brand name where generic equivalent is available)	\$5 <u>co-pay</u> + difference in cost between brand name and generic (retail); \$12.50 <u>co-pay</u> + difference in cost between brand name and generic (mail/ 90-day retail).	Not covered.	
	<u>Specialty drugs</u>	Covered under applicable physician or medical facility benefit or <u>prescription drug</u> category.	Covered under applicable physician or medical facility benefit. Not covered under <u>prescription</u> benefit.	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> for hospital after <u>deductible</u> .	<u>Preauthorization</u> required. Ambulatory surgery center not covered for Tier 2 <u>Out-of-Network</u> .
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	None.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$75 <u>co-pay</u> + 10% <u>coinsurance</u> after Tier 1 <u>deductible</u> .	\$75 <u>co-pay</u> + 10% <u>coinsurance</u> after Tier 1 <u>deductible</u> .	<u>Co-pay</u> waived if admitted to hospital
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u> .	<u>Coinsurance</u> after <u>deductible</u> , based on the tier level of facility to which the individual is transported (Tier 1: 10%; Tier 2 <u>Out-of-Network</u> : 40%)	Air ambulance services are covered at the Tier 1 benefit level regardless of whether the <u>provider</u> is a Tier 1 <u>provider</u> or a Tier 2 <u>Out-of-Network provider</u> .

Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	<u>Urgent care</u>	\$15 <u>co-pay</u> , then <u>deductible</u> ; Other services provided in office setting: 10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$100 <u>co-pay/day</u> (maximum of \$500) + 10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required. Limited to charge for semi-private room.
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office Visit: \$15 <u>co-pay</u> , then <u>deductible</u> .  Other outpatient services: 10% <u>coinsurance</u> after <u>deductible</u> .  Laborers' Addiction Program: 10% <u>coinsurance</u> , no <u>deductible</u> .	Office Visit: 40% <u>coinsurance</u> after <u>deductible</u> .  Other outpatient services: 40% <u>coinsurance</u> after <u>deductible</u> .  Laborers' Addiction Program: Not covered.	Services are covered only when provided by licensed mental/behavioral health <u>providers</u> .  The Laborers' Addiction Program is offered only for services provided by three specific Tier 1 <u>providers</u> and has certain specific requirements. Please contact the Fund Office at (314) 644-2777 for more information.
	Inpatient services	\$100 <u>co-pay/day</u> (maximum of \$500) + 10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required.
<b>If you are pregnant</b>	Office visits	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> ; Other services provided in office setting: 40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required. No charge for prenatal <u>preventive</u> care from Tier 1 <u>providers</u> . No coverage for dependent child's pregnancy or newborn, unless part of the customary global physician package for prenatal care. No <u>out-of-network</u> coverage for

Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	No charge for delivery related physician care (if included in global package). \$100 <u>co-pay/day</u> (maximum of \$500) + 10% <u>coinsurance</u> after <u>deductible</u> for other services and hospital facility charges.	40% <u>coinsurance</u> after <u>deductible</u> .	dependent child's pregnancy. No coverage for non-routine prenatal care of dependent child. No coverage for dependent <u>pregnancy complications</u> .
	Childbirth/delivery facility services			
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required. Maximum of 100 visits/year.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	Tier 2 <u>Out-of- Network</u> maximum of 30 visits/year.
	<u>Habilitation services</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Preauthorization</u> required. Maximum 90-days/year.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	<u>Co-pay</u> , <u>Deductible</u> and <u>Coinsurance</u> do not apply to items provided by a Tier 1 <u>provider</u> and determined to be <u>preventive care</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u> after <u>deductible</u> .	40% <u>coinsurance</u> after <u>deductible</u> .	Only covered when individual has less than six months to live. Maximum of 15 bereavement counseling visits/year.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$10 <u>co-pay</u> .	100% <u>coinsurance</u> after the first \$45.	There is only one vision <u>network</u> . Limited to 1 exam/year.
	Children's glasses	\$20 <u>co-pay</u> for lenses, frames, or both. 100% <u>coinsurance</u> after the first \$180 for frames after 20% discount from <u>network provider</u> .	\$20 <u>co-pay</u> for lenses, frames, or both. 100% <u>coinsurance</u> after the first \$30 (single vision), \$50 (bifocal), \$60 (trifocal), \$75 (lenticular). 100%	There is only one vision <u>network</u> . Maximum of 1 pair of lenses and 1 frame/year.

Common Medical Event	Services You May Need	Tier 1 <u>Provider</u> (You will pay the least)	Tier 2 <u>Out-of-Network Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
			<u>coinsurance</u> after the first \$70 (frames).	
	Children's dental check-up	No charge.	No charge if the charge is equal to or less than the maximum <u>plan</u> allowance for a <u>network</u> 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.)**

- Cosmetic surgery except when due solely to an accidental injury or solely to a birth defect, provided such treatment is undertaken as soon as is medically feasible
- Gene Therapy Treatments
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S

**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
- Bariatric surgery performed by a Tier 1 provider at a Tier 1 facility for medically necessary treatment of morbid obesity. One surgery per lifetime, \$50,000 maximum benefit. Excluded from out-of-pocket limit. No coverage for dependent children.
- Chiropractic care, maximum of 60 visits per calendar year for Tier 1 and Tier 2 Out-of-Network combined; only 26 of those visits can be Out-of-Network
- Dental care (Adult)
- 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 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](http://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](http://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](http://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](http://www.insurance.mo.gov), or email [consumeraffairs@insurance.mo.gov](mailto: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 1-800-489-0228.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-489-0228.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-489-0228.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-489-0228.

————— *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 <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	10%
■ <u>Other</u> <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,860</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ <u>Hospital (facility)</u> <u>coinsurance</u>	10%
■ <u>Other</u> <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,080</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ <u>Hospital (facility)</u> <u>copayments</u>	10%
■ <u>Other</u> <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$700</b>

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