LABORERS' BENEFITS · ST. LOUIS

SUMMARY OF BENEFITS

Active and Retiree

QUALIFYING QUARTERS	COVERAGE QUARTERS
SEPTEMBER – OCTOBER – NOVEMBER	JANUARY – FEBRUARY - MARCH
DECEMBER – JANUARY – FEBRUARY	APRIL – MAY – JUNE
MARCH – APRIL – MAY	JULY – AUGUST – SEPTEMBER
JUNE – JULY – AUGUST	OCTOBER – NOVEMBER – DECEMBER

MEDICAL / BEHAVIORAL CARE BENEFITS

	PPO/ASO Tier 1 Network	National Network Tier 2 Network	OUT-OF-NETWORK Tier 3 Network
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	$400	$400	$500
FAMILY CALENDAR YEAR DEDUCTIBLE	$800	$800	$1,000
COINSURANCE	10%	20%	40%
INDIVIDUAL OUT-OF-POCKET MAXIMUM	$4,000	$4,000	NO MAXIMUM
FAMILY OUT-OF-POCKET MAXIMUM	$5,000	$5,000	NO MAXIMUM
OFFICE, URGENT CARE & MED STOP VISITS	$15 co-pay each visit then deductible	$15 co-pay each visit then deductible	Covered subject to deductible & coinsurance
OTHER SERVICES IN OFFICE SETTING	Deductible & coinsurance	Deductible & coinsurance	Covered subject to deductible & coinsurance
CERTAIN PREVENTIVE SERVICES	Covered at a 100%.	Covered at a 100%.	60% after deductible
HOSPITAL EMERGENCY ROOM CO-PAY	$75 then applicable to deductible & coinsurance	$75 then applicable to deductible & coinsurance	$75 then applicable to Deductible, 20% coinsurance & No Out-of-Pocket Max.
CHIROPRACTIC VISIT	60 visits	60 visits	26 visits
PLAN YEAR MAXIMUM BENEFIT	No limit as of July 1, 2014		

DENTAL BENEFITS

	DELTA DENTAL PPO DENTISTS ONLY	DELTA DENTAL PREMIER AND NON-NETWORK DENTISTS
TYPE A – ROUTINE & PREVENTIVE CARE	100%	100%
TYPE B – BASIC SERVICES	90% after deductible $1,500 per calendar year	80% after deductible $1,500 per calendar year
TYPE C - PROSTHETICS	60% after deductible $1,500 per calendar year	50% after deductible $1,500 per calendar year
TYPE D - ORTHODONTICS	80% after deductible $2000 Lifetime	80% after deductible $2000 Lifetime
For all covered TMJ charges, $3,000 lifetime after deductible.		

2357 59th Street St. Louis, Missouri 63110 (314)644-2777 (800)489-0228 Fax: (314)646-4440
www.stllaborers.com

PRESCRIPTION BENEFITS

	MAXIMUM SUPPLY	GENERIC	SINGLE SOURCE BRAND	MULTI-SOURCE BRAND
RETAIL	30 days	$5.00	$25.00	$5.00 plus the difference between brand & generic cost
RETAIL CHOICE 90 OR MAIL ORDER	90 days	$12.50	$62.50	$12.50 plus the difference between brand & generic cost

Single source brand drugs are name brand drugs that do not have a generic equivalent drug available. Multi-source brand drugs are brand name drugs that do have a generic drug available.

VISION BENEFITS – VSP PARTICIPATING PROVIDER

VISION EXAM	$10 co-pay - Every 12 Months
PRESCRIPTION EYE GLASSES	$20 co-pay & $180 Allowance on Frames - Every 12 Months
CONTACT LENSES WITH EXAM	$20 co-pay & $300 Allowance - Every 12 Months (Instead of glasses)

For Non-Participating provider benefit refer to your Summary Plan Description.

MEMBER ASSISTANCE PROGRAM BENEFITS (MAP)

OUTPATIENT SHORT TERM COUNSELING WITH A MAP COUNSELOR	Covered at a 100% for a maximum of 6 visits.

WEEKLY DISABILITY BENEFITS

BENEFITS BEGIN	On the 3rd working day following the day you became disabled
BENEFITS AMOUNT	$150 Per Week. ($30 per day excluding Saturdays and Sundays)
BENEFITS DURATION	Maximum of 13 weeks for each period of disability

HEARING AID BENEFITS

INDIVIDUAL HEARING AID CO-PAYMENT	$25 Per Hearing Aid
BENEFIT AMOUNT	$1,500 Per Hearing Aid
BENEFIT PERIOD	One Hearing Aid per ear each 48 months

DEATH BENEFITS

ACTIVE PARTICIPANT (LIFE)	$10,000 Maximum
ACTIVE PARTICIPANT (ACCIDENTAL DEATH & DISMEMBERMENT	$10,000 Maximum
COVERED DEPENDENTS: SPOUSE & CHILD(REN) (LIFE)	$2,000 Maximum
RETIRED PARTICIPANT (LIFE)	$2,500 Maximum

RETIREE BENEFIT PREMIUMS

RETIREE ONLY	$395 PER MONTH
SPOUSE OF RETIREE	$475 PER MONTH
RETIREE AND SPOUSE	$870 PER MONTH
RETIREE AND CHILDREN	$1,142 PER MONTH
RETIREE, SPOUSE AND CHILDREN	$1,618 PER MONTH

Retiree Benefits are for retirees and dependents under age 65 that are not eligible for Medicare. These are the same benefits as active members receive, except retirees are not eligible for weekly disability benefits and life insurance benefits are reduced. The Retiree rates are effective 1-1-2016 and they are the preferred rates. For non-preferred rates contact the Benefit Office.

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