LABORERS' BENEFITS • ST. LOUIS

SUMMARY OF BENEFITS
NBUE

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.		

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
CHOICE 90 OR MAIL	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

VISION EXAM	Once Every 12 Months (Lenses and Frames)
PRESCRIPTION EYE GLASSES	Once Every 12 Months
CONTACT LENSES	Once Every 12 Months (Instead of glasses)
VSP PROVIDER	Maximum benefit of $300 for both exam and lenses combined.
NON-VSP PROVIDER	$170 for "Visually Necessary" contact lenses.

MEMBER ASSISTANCE PROGRAM BENEFITS (MAP)

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

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

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