Carpenters' Health and Welfare Trust Fund of St. Louis

Schedule of Plan Benefits – Effective January 1, 2018

carpenters' benefit plans
HEALTH & RETIREMENT SERVICES

MEDICAL BENEFIT			
PLAN PROVISION	**HOW IT WORKS**		
	Network		**Out-of-Network**
	Platinum Plan	**Gold Plan**	
Annual deductible	$200/Individual $600/Family	$300/Individual $900/Family	**Platinum:** $600/Individual $1,800/Family **Gold:** $800/Individual $2,400/Family
Annual out-of-pocket maximum	$2,000/Individual $6,000/Family	$4,000/Individual $7,700/Family	Unlimited
Coinsurance	90%	80%	50%
PREVENTIVE CARE *Subject to age and frequency guidelines.*			
Routine preventive care	100%, no deductible	100%, no deductible	50% after deductible
Annual physical	100%, no deductible	100%, no deductible	50% after deductible
Well-woman visits	100%, no deductible	100%, no deductible	50% after deductible
Well-child care	100%, no deductible	100%, no deductible	50% after deductible
Immunizations	100%, no deductible	100%, no deductible	50% after deductible
Screenings and diagnostic tests • Routine mammography • Pap test • Prostate specific antigen (PSA) test • Colonoscopy • Lung cancer screening • Other preventive screenings and tests	100%, no deductible	100%, no deductible	50% after deductible
DOCTORS' OFFICE VISITS *Including diagnostic x-rays and tests performed in the doctor's office.*			
Primary care physician	$25 copay	$25 copay	50% after deductible
Specialist	$50 copay	$50 copay	50% after deductible
Prenatal care	100%, no deductible	100%, no deductible	50% after deductible
Chiropractic care	$10 copay	$10 copay	50%, no deductible
	Combined maximum of 40 visits annually.		
HOSPITAL SERVICES			
Inpatient care	90% after deductible	80% after deductible	50% after deductible*
Outpatient care	90% after deductible	80% after deductible	50% after deductible*
Routine nursery care	90% after deductible	80% after deductible	50% after deductible*
Diagnostic, radiology, laboratory and pathology	90% after deductible	80% after deductible	50% after deductible*
Physician and specialist services	90% after deductible	80% after deductible	50% after deductible*
Surgery	90% after deductible	80% after deductible	50% after deductible*

MEDICAL, continued			
PLAN PROVISION	**HOW IT WORKS**		
	Network		**Out-of-Network**
	Platinum Plan	**Gold Plan**	
EMERGENCY AND URGENT CARE			
Emergency room care & services	$250 copay	$300 copay	**Platinum:** $250 copay **Gold:** $300 copay
	Copay waived if admitted to hospital, but hospital coverage provisions will then apply. No benefits are payable if you use the emergency room for non-emergency care.		
Urgent care & services	$75 copay	$75 copay	50% after deductible
Ambulance (ground)	$150 copay	$300 copay	**Platinum:** $150 copay **Gold:** $300 copay
Ambulance (air or water)	$1,000 copay	$1,000 copay	$1,000 copay*
MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT *Certain services require prior authorization.*			
Inpatient care	90% after deductible	80% after deductible	50% after deductible*
Outpatient care	90% after deductible	80% after deductible	50% after deductible*
OTHER COVERED SERVICES *Certain services require prior authorization.*			
Hearing Aid benefit**	90% after deductible	90% after deductible	90% after deductible
Durable medical equipment	90% after deductible	80% after deductible	50% after deductible*
Home health care	90% after deductible	80% after deductible	50% after deductible*
	Combined maximum of 100 visits per Plan year.		
Hospice care	90% after deductible	80% after deductible	50% after deductible*
Diagnostic, radiology, laboratory and pathology at standalone outpatient facility	90% after deductible	80% after deductible	50% after deductible*
Short-term rehabilitation (physical, speech and occupational therapy)	90% after deductible	80% after deductible	50% after deductible*
	Combined maximum of 60 visits per Plan year.		
Convalescent skilled nursing facility	90% after deductible	80% after deductible	50% after deductible*
	Combined maximum of 100 days per Plan year.		

**Patient's responsibility to secure required prior authorization.*
***Up to $2,000 maximum per ear, every five (5) years – **Member Only** benefit*

PRESCRIPTION DRUG BENEFIT		
PRESCRIPTION DRUG TYPE	**WHAT THE MEMBER PAYS**	
	Platinum Plan	**Gold Plan**
RETAIL ***(Up to a 30-day supply per prescription purchased at a Retail Pharmacy)***		
Generic	10% *$10 min / $50 max*	20% *$10 min / $50 max*
Preferred brand-name	35% *$20 min / $75 max*	35% *$20 min / $75 max*
Non-preferred brand-name	40% *$20 min / $125 max*	40% *$20 min / $125 max*
Diabetes and insulin supplies	10% *$10 min / $50 max*	10% *$10 min / $50 max*
MAIL ORDER ***(Up to a 90-day supply filled through Express Scripts Home Delivery)***		
Generic	10% *$20 min / $100 max*	20% *$20 min / $100 max*
Preferred brand-name	35% *$40 min / $150 max*	35% *$40 min / $150 max*
Non-preferred brand-name	40% *$40 min / $250 max*	40% *$40 min / $250 max*
Diabetes and insulin supplies	10% *$20 min / $100 max*	10% *$20 min / $100 max*
RETAIL 90 (R90) ***(Up to a 90-day supply per prescription filled at a Retail Pharmacy)***		
Generic	10% *$20 min / $125 max*	20% *$20 min / $125 max*
Preferred brand-name	35% *$40 min / $200 max*	35% *$40 min / $200 max*
Non-preferred brand-name	40% *$40 min / $350 max*	40% *$40 min / $350 max*
Diabetes and insulin supplies	10% *$20 min / $125 max*	10% *$20 min / $125 max*
SPECIALTY MEDICATIONS		
Preferred brand-name	35% *$40 min / $150 max*	35% *$40 min / $150 max*
Non-preferred brand-name	40% *$40 min / $250 max*	40% *$40 min / $250 max*
Drugs approved by FDA on or after 1/1/2013	50% *No maximum*	50% *No maximum*
ANNUAL MAXIMUM		
Individual out-of-pocket maximum Family out-of-pocket maximum	$3,350 $7,000	

DENTAL BENEFIT			
DENTAL BENEFIT COVERAGE CATEGORY	**Delta Dental Plan**		**Out of Network**
	PPO	**Premier**	
Deductible (Preventive)	$0/none	$50	$75
Preventive Services	0% coinsurance	25% coinsurance	50% coinsurance
Deductible (All other benefits)[1]	$50	$75	$75
Basic Services	20% coinsurance	50% coinsurance	75% coinsurance
Major Services	50% coinsurance	60% coinsurance	75% coinsurance
Annual Maximum[2]	$1,500 with Max Advantage		
Orthodontia Services	50% coinsurance		
Ortho Lifetime Max	$1,500	$1,500	$1,500
SPECIAL PROVISIONS			
Accident Provision	90% of the Maximum Payable Amount, no deductible, no max		
Max Advantage[3]	Included		
Healthy Smiles/Healthy Lives[4]	Basic Option: extra cleanings for designated health conditions		
[1] Deductible is cumulative. If the $50 deductible is met for preventive services from a Delta Dental Premier dentist, the patient only has an additional $25 to reach the $75 deductible. If the first services received are basic/major, the deductible is $75.			
[2] Annual Maximum does not apply to children ages 0-19 for preventive dental services.			
[3] MaxAdvantage does not apply out-of-pocket maximum to routine exams and cleanings if obtained twice a year.			
[4] Healthy Smiles Healthy Lives allows for increased cleaning for individuals with certain diagnoses.			
EXAMPLES OF DENTAL PROCEDURES			
Preventive Services: Routine exam, cleaning, routine x-rays Basic Services: Extractions, amalgam fillings, root canal therapy Major Services: Crowns, fixed bridgework and dentures			

VISION BENEFIT			
VISION SERVICE OR SUPPLY	**VSP Provider Copay**	**VSP Provider Maximum Benefit**	**Non-VSP Provider Maximum Benefit**
Routine Eye Examination *Every 12 months*	$10	0% coinsurance after copay	$38, after $10 copay
Eyeglass Frames *Every 24 months*	$25	Covered up to $150 after copay	$45, after $25 copay
Eyeglass Lenses *One pair every 12 months* Single Vision Lined bifocal Lined trifocal Lenticular	None	0% coinsurance *(covered at 100%)*	 $31 $51 $64 $80
Contact Lenses *Every 12 months* Medically necessary; prior authorization Elective	None	0% coinsurance *(covered at 100%)* $150	 $210 $105

The services and supplies listed in the Vision schedule are covered only if performed by a licensed optometrist, ophthalmologist, or dispensing optician. Covered eye exams include an evaluation of visual function and prescription corrective lenses, if needed.