

275 HOURS*

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

*If you work outside of the St. Louis jurisdiction you may need more or less than 275 hours for eligibility.

MEDICAL / BEHAVIORAL CARE BENEFITS

	Tier 1 Network Aetna Choice POS II	Tier 2 Network Out-of-Network
INDIVIDUAL CALENDAR YEAR DEDUCTIBLE	\$400	\$500
FAMILY CALENDAR YEAR DEDUCTIBLE	\$800	\$1,000
COINSURANCE	10%	40%
INDIVIDUAL OUT-OF-POCKET MAXIMUM	\$4,000	NO MAXIMUM
FAMILY OUT-OF-POCKET MAXIMUM	\$5,000	NO MAXIMUM
OFFICE VISITS & URGENT CARE	\$15 co-pay each visit then deductible	Covered subject to deductible & coinsurance
OTHER SERVICES IN OFFICE SETTING	Deductible & coinsurance	Covered subject to deductible & coinsurance
INPATIENT SERVICES	\$100 co-pay per day (\$500 maximum)	40% after deductible
CERTAIN PREVENTIVE SERVICES	Covered at a 100%	40% after deductible
HOSPITAL EMERGENCY ROOM CO-PAY	\$75 then applicable to deductible & coinsurance	\$75 then applicable to Deductible, 10% coinsurance
CHIROPRACTIC VISITS	60 visits	26 visits

MARATHONHEALTH

	CO-PAY	DEDUCTIBLE	CO-INSURANCE
MARATHON HEALTH SERVICES	\$0.00*	\$0.00*	\$0.00*

*No copay or deductible for most services, including office visit, generic prescriptions, and lab work. For more information visit stlouislaborers.com/marathon or call (866) 808-6005.

TELEMEDICINE BENEFITS

	CO-PAY	DEDUCTIBLE	CO-INSURANCE
TELEMEDICINE* SERVICES THROUGH CVS HEALTH VIRTUAL CARE	\$0.00*	\$0.00*	\$0.00*

You can access the CVS Health Virtual Care benefit online at www.cvs.com/virtual-care, by calling 1-866-211-5678 or you can download their app. *If you use telemedicine services through your doctor, those visits will be subject to co-pays, deductible, and co-insurance.



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
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 per issue.
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WEEKLY DISABILITY BENEFITS (For Active Members)

BENEFITS BEGIN	On the 3rd working day following the day you became disabled
BENEFITS AMOUNT	\$300 Per Week. (\$60 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

