

## MASONRY SECURITY TRUST

### Plan Summary for Active Employees and Dependents

Medical Benefits	PPO Providers	Non PPO Providers
Deductible – Per Person Each Calendar Year Deductible incurred <b>only</b> in the last three months of a calendar year may be applied to the current and the following year's deductible	\$200 with a maximum of \$600 per family	\$200 with a maximum of \$600 per family
Out of Pocket Amounts – Per Person Each Calendar Year. Does not include Outpatient Nervous & Mental, Emergency copay or prescription copays.	\$2,000	\$2,000
Maximum Per Person While Insured	\$1,000,000	\$1,000,000
Hospital Services & Supplies – Inpatient and Outpatient	80%	60%
Ambulance Services	80% deductible waived	80% deductible waived
Emergency Room Copay	\$100- waived if admitted	\$100 – waived if admitted
Physician Services billed by the physician	80%	80%
Chiropractic Services	80% to a maximum of \$25 per visit and 20 visits per calendar year.	80% to a maximum of \$25 per visit and 20 visits per calendar year.
Diagnostic X-ray and Lab	80%	80%
Home Health	80% up to 130 visits per calendar year; includes nursing services	60% up to 130 visits per calendar year; includes nursing services
Hospice Care	80% up to 185 days while insured; includes nursing services	60% up to 185 days while insured; includes nursing services
Chemical Dependency <b>NOTE: ALL INPATIENT CONFINEMENTS REQUIRE PRECERTIFICATION BEFORE THE CONFINEMENT BEGINS. FAILURE TO OBTAIN PRECERTIFICATION <i>PRIOR</i> TO INPATIENT TREATMENT WILL RESULT IN A \$100 PENALTY. THIS AMOUNT WILL NOT APPLY TO THE OUT OF POCKET LIMIT.</b>	Inpatient and Outpatient: 80% to greater of: \$10,000, or amount adjusted for CPI, in 24 consecutive months	Inpatient and Outpatient: 60% to greater of \$10,000, or amount adjusted for CPI, in 24 consecutive months
Mental Health	Inpatient – 80% up to 10 days each calendar year. Outpatient –80% up to 20 visits each calendar year. Outpatient benefits are not applied to the	Inpatient – 60% up to 10 days each calendar year. Outpatient –60% up to 20 visits each calendar year. Outpatient benefits are not applied to the

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	out of pocket amounts.	out of pocket amounts.
Neurodevelopmental Services	80% after the deductible Limited to children under age 6	60% after the deductible Limited to children under age 6
Maternity	80% after the deductible. Includes prenatal testing and routine nursery charges	60% after the deductible. Includes prenatal testing and routine nursery charges
Voluntary Sterilization	80%	60%
Durable Medical Equipment	80% Includes repair and replacement due to normal use or growth of a child	60% Includes repair and replacement due to normal use or growth of a child
Prostheses	80% Includes repair and replacement due to normal use or growth of a child	60% Includes repair and replacement due to normal use or growth of a child
Special Items (such as braces, crutches, surgical and orthopedic appliances, syringes, dressings for wounds, oxygen)	80%	60%
Blood Bank Charges	80%	60%
Formulas for PKU	80%	60%
Skilled Nursing Facility	80% up to 30 days per calendar year	60% up to 30 days per calendar year
Rehabilitation Care Inpatient	80% Up to 60 days per calendar year	80% Up to 60 days per calendar year
Outpatient	Physical & Occupational Therapy—up to 60 visits per calendar year Speech Therapy – up to 30 visits per calendar year	Physical & Occupational Therapy—up to 60 visits per calendar year Speech Therapy – up to 30 visits per calendar year
Preadmission Testing	80%	60%
Dental Injury	80%	60%
Smoking Cessation	80% with no deductible to a maximum of \$300 while insured. Must be done in conjunction with behavioral modification program and physician must certify that the program has been completed.	60% with no deductible to a maximum of \$300 while insured. Must be done in conjunction with behavioral modification program and physician must certify that the program has been completed.
Services for massage therapy, naturopaths and acupuncture	Physician – 80% up to \$1,000 each calendar year	Physician – 60% up to \$1,000 each calendar year
Routine Services		
Physical Exam – age 18 and Over. Includes routine pap charges	100% up to \$200 per calendar year, deductible waived	100% up to \$200 per calendar year, deductible waived

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Preventative Care – birth to age 18	100% up to \$200 per calendar year, deductible waived	100% up to \$200 per calendar year, deductible waived
Childhood Immunizations - to age 7	100%, deductible waived	100%, deductible waived
Routine Mammograms	100%, deductible waived	100%, deductible waived
Transplant Services	80%. Requires pre-approval before services are provided. Includes donor charges. Includes charges for travel expenses for distances more than 30 miles up to \$2,500 per transplant episode.	60%. Requires pre-approval before services are provided. Includes donor charges. Includes charges for travel expenses for distances more than 30 miles up to \$2,500 per transplant episode.
Prescription Drugs		
<p><u>Retail Card</u>- For up to a 34 day supply or 100 units per prescription, whichever is greater. \$10 minimum copay and \$100 maximum copay per prescription                  Diabetic supplies - \$10 copay, <b>Generic</b> paid at 90%; <b>Brand</b> (with no generic equivalent) paid at 80%; <b>Brand</b> (DAW [Dispensed As Written] ) 70% and <b>Brand</b> (No DAW) 70%. If brand is purchased when a generic equivalent is available and the prescription is not written as DAW, plan will provide benefit equivalent to the cost of the generic drug.</p> <p><u>Mail Order</u>- For up to a 102 day supply or 300 units per prescription, whichever is greater. \$300 maximum copay per 102 day or 300 unit per prescription.                  Diabetic supplies - \$10 copay, <b>Generic</b> paid at 90%; <b>Brand</b> (with no generic equivalent) paid at 80%; <b>Brand</b> (DAW [Dispensed As Written] ) 70% and <b>Brand</b> (No DAW) 70%. If brand is purchased when a generic equivalent is available and the prescription is not written as DAW, plan will provide benefit equivalent to the cost of the generic drug.</p> <p><u>Out of Network</u>-60% reimbursement. If brand is purchased when a generic equivalent is available and the prescription is not written as DAW, plan will provide benefit equivalent to the cost of the generic drug. The 40% balance will not apply to out of pocket expenses or the deductible.</p> <p><u>Out Of Pocket Maximum for Prescriptions</u> (separate from the medical out of pocket amount) - \$5,000 per family</p>		
<b>Dental Services</b>		
Deductible	\$50 per person and \$100 per family each calendar year	
Maximum	\$1,500 per person per calendar year for all services combined	
Benefits	Pays 100% of the service up to the maximum <b>scheduled</b> amount for each service. Periodontal procedures are limited to \$500 per calendar year	
Alternate Benefit	The benefit is provided for the least costly procedure when optional techniques of treatment are available.	

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<b>Vision Benefits</b>	
Deductible	None
Benefits	100% up to the maximum <b>scheduled</b> amount. One examination each calendar year. Two lenses are available each calendar year and frames are available each two calendar years. Single Lenses                                 \$ 60 per pair per year Bifocal Lenses                                 \$ 80 per pair per year Trifocal Lenses                                 \$100 per pair per year Lenticular/Aphakic Lenses                 \$150 per pair per year Frames   \$ 50 every two calendar years Medically Necessary Contacts             \$220 per pair each calendar year Cosmetic Contacts                             \$250 per pair each calendar year
<b>Weekly Time Loss Benefit – Employee Only</b>	Up to \$150 per week if unable to work at your own job or occupation for non occupational injuries or sickness to a maximum of 26 weeks
<b>Life Insurance</b>	Employee - \$4,000. Dependents –spouse or student - \$1,500; child under age 6 months - \$150; child 6 months and older - \$1,500.
<b>Accidental Death &amp; Dismemberment – Employee Only</b>	\$4,000 for loss of life. \$2,000 for loss of one hand, one foot or sight of one eye.
<b>Telephone Numbers</b>	
Bricklayers' Union Office	206-248-2456
Northwest Administrators – for questions on eligibility and claims information	(206)926-2842 or 1-866-312-4591
Express Scripts, Inc. (Prescription Drugs)	1-800-467-2006 (24 hours a day, seven days a week)
First Choice Health Network	1-888-528-7304 (precertification)

#### **Coordination of Benefits**

The Plan is designed to help meet the cost of medical, dental and vision care expenses. It is not intended that you receive greater benefits than the actual expenses incurred. The amount payable under this Plan will take into account any coverage you have under other plans. This means the benefits of this Plan will be coordinated with the benefits of the other plans. These plans mean any plan under which medical, dental or vision benefits or services are provided by group insurance or any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis). When coordinating, the primary plan pays benefits first and then the secondary plan pays benefit after the primary plan has paid.

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If you have more than one plan of insurance coverage, you must notify each insurance carrier of the existence of all group coverages you or your family may have. **There is no Coordination of Benefits for prescription drugs received through any retail card plan or mail order plan.**

#### Medicare

The Plan will coordinate with Medicare Parts A and B, **whether or not enrolled**. If you have active eligibility and are Medicare eligible, this Plan is primary as long as there is active eligibility. Medicare coverage would then be secondary. Once active eligibility ceases, or you become a retiree, Medicare will become primary. There is specific criteria for coordination with Medicare for persons with end stage renal disease; please contact the administration office for more information.

Eligibility for Medicare may also affect your ability to obtain or continue coverage under any COBRA provision of the Plan. The contribution for any COBRA continuation provision or your contribution for retiree coverage may be affected by Medicare eligibility. Please contact the Trust Office for information and assistance.

**THIS PLAN SUMMARY IS PROVIDED FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT INTENDED AS A CONTRACT. ALL CLAIMS ARE SUBJECT TO MEDICAL NECESSITY AND ALL POLICY PROVISIONS. A COMPLETE DESCRIPTION OF THE PLAN WILL BE PROVIDED BY THE POLICYHOLDER IN YOUR MEMBERSHIP PACKET WHEN YOU BECOME ELIGIBLE FOR COVERAGE.**