Benefits at a Glance

April 2020 Update

NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST

Coverage under this Trust's Benefit Plan will take effect when you satisfy the eligibility requirements. Once the 350-hour minimum eligibility requirements have been met, you will be eligible for medical and prescription benefits provided by the Plan. Coverage for dental, vision and life and personal loss coverage becomes effective once you have met the 1,000 hour requirement. A summary of the hour bank eligibility rules can be found on the back of this brochure.

Benefits at a Glance provides a brief overview of the benefits provided by the Trust. A complete description of all eligibility rules, benefits, definitions, limitations and exclusions is in the official Plan Booklet, including the Summaries of Material Modifications. You'll receive a Plan Booklet and ID card in the mail during your first month of eligibility.

Premera Blue Cross network of providers can be found at www.premera.com/sharedadmin or by calling (800)-810-2583.

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
Individual	$500	$500
Family	$1,500	$1,500
ANNUAL OUT-OF-POCKET MAXIMUM ON COVERED MEDICAL & SPECIALTY DRUG CHARGES		
Individual	$4,500	Unlimited
Family	$4,500	Unlimited
ANNUAL MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS	$20 co-pay then 85% after deductible	$20 co-pay then 70% after deductible
OUTPATIENT LAB & RADIOLOGY	85% after deductible	70% after deductible
IN-PATIENT HOSPITAL SERVICES	85% after deductible	70% after deductible
EMERGENCY ROOM Co-pay waived if visit is within 24 hours of an accidental injury or for a life threatening illness	$150 co-pay then 85% after deductible	$150 co-pay then 70% after deductible
TELADOC	$10 co-pay, no deductible	
Medical & Dermatology - Behavioral Health for participants over the age of 18. Board Certified Physicians provide diagnosis and treatment via phone or video call. For questions about Teladoc call: 855-332-4059		
OUTPATIENT SURGERY	85% after deductible	70% after deductible
AMBULANCE To nearest hospital only	85% after deductible	85% after deductible
ROUTINE AND PREVENTIVE CARE One routine physical exam per calendar year; annual cancer screenings, well baby care, immunizations and vaccinations.	100% no deductible	70% after deductible $20 co-pay

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
PREGNANCY Prenatal, delivery, inpatient services & postnatal care.	85% after deductible	70% after deductible
BESTBEGINNINGS MATERNITY RESOURCE PROGRAM For eligible participants, if you enroll and complete the pregnancy survey within the first 16 weeks of pregnancy, the newborn's annual deductible will be waived for the year of birth. To enroll, download the BestBeginnings app in the Google Play or Itunes app store. You can also contact the Trust Office customer service to request a paper version of the survey.		
THERAPY SERVICES **PHYSICAL, OCCUPATIONAL & MASSAGE THERAPY** Up to 100 days following accident, stroke or surgery. All other conditions, or following the first 100 days, visits are subject to a combined limit of 30 visits per calendar year.	85% after deductible	70% after deductible
CARDIO AND PULMONARY REHABILITATION	85% after deductible	70% after deductible
SPEECH THERAPY Only to restore lost speech following injury or illness **NOTE:** *The limitations listed under Therapy Services do not apply to treatment of developmental conditions listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM).*	85% after deductible	70% after deductible
SPINAL MANIPULATIONS 24 visits per calendar year - participants 12 visits per calendar year – dependents	85% after deductible $25 max benefit per visit	70% after deductible $25 max benefit per visit
MENTAL HEALTH CARE Office Visits In-patient	$20 co-pay then 85% after deductible 85% after deductible	$20 co-pay then 70% after deductible 70% after deductible
SUBSTANCE USE TREATMENT Office Visits In-patient	$20 co-pay then 85% after deductible 85% after deductible	$20 co-pay then 70% after deductible 70% after deductible

WHAT IS NOT COVERED

This is an abbreviated list of exclusions. A complete listing of benefits, eligibility rules, limitations and exclusions is in the booklet.

- Services not medically necessary
- Services or supplies that are experimental or investigative, except as provided for under the Affordable Care Act
- Abortion (elective)
- Infertility, including assisted fertilization techniques
- Reversal of voluntary sterilization
- Custodial care
- Educational or vocational testing
- Exercise programs
- Hair loss, except for up to one wig following the loss of hair due to chemotherapy
- Cosmetic services and supplies
- Complications of non-covered treatments
- Expenses related to organ donation for non-member recipients
- Travel and accommodation expenses
- Occupational injury or sickness
- Expenses related to injury or sickness caused by a third party where an opportunity for recovery exists
- Government coverage. Care and services furnished by a program or agency funded by any government
- Expenses related to Injury or Sickness sustained while engaging in illegal acts including DUI

Summary of Prescription Benefits

The Plan contracts with a Pharmacy Benefit Manager, OptumRx to provide prescriptions at a discounted rate through Participating Retail Pharmacies. The Mail Order Pharmacy option is provided by OptumRx.

PARTICIPATING PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30-day supply or 100 unit dose	$5	$15 plus 15% of the balance
NON-PARTICIPATING PHARMACY	**GENERIC CO-PAY**	**BRAND CO-PAY**
Up to a 30-day supply or 100 unit dose You MUST pay for the prescription and submit a claim to OptumRx for reimbursement.	$15 plus 50% of the balance	$15 plus 50% of the balance
MAIL ORDER PHARMACY OPTION	**GENERIC CO-PAY**	**BRAND CO-PAY**
For maintenance prescriptions up to 100 day supply or 300 unit dose	No co-pay	$15 plus 15% of the balance

RETAIL PHARMACY BENEFIT OPTION – OptumRx

Once you become eligible for benefits, you can locate retail pharmacies in the OptumRx network by visiting their website at www.optumrx.com; or call OptumRx customer service at (888)-354-0090.

NON-PARTICIPATING RETAIL PHARMACY BENEFIT

Covered prescription drugs purchased at Non-Participating Pharmacies will be reimbursed at 50% of covered charges following a $15 co-pay. You must pay for the prescription at the pharmacy and submit a claim form with your prescription receipt to OptumRx, for reimbursement. Claim forms can be obtained by calling OptumRx customer service at (888)-354-0090.

MAIL ORDER PHARMACY BENEFIT OPTION – OptumRx

This option is available through OptumRx for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Prescriptions are filled by mailing or faxing your doctor's prescription form to OptumRx. For questions regarding the Mail Order option, contact OptumRx at (888)-354-0090.

OVER-THE-COUNTER PHARMECUTICALS AND TOBACCO CESSATION PRODUCTS

The Trust will pay 100% of the cost of a limited number of over-the-counter pharmaceuticals and tobacco cessation products approved by the FDA. Limitations may apply.

- Aspirin: when prescribed by a physician for the prevention of cardiovascular disease for men and women ages 55 – 79.
- Folic Acid: when prescribed by a physician for women up to age of 50.
- Tobacco Cessation: products approved by the FDA for tobacco cessation and prescribed by a physician, including oral medications, inhalers, nicotine patches or nicotine gum.

Summary of Dental Benefits

Participants with Active coverage under the Northwest Laborers-Employers Health & Security Trust must choose between Dental Plan A and Dental Plan B. You will be given an opportunity to make your selection once you have established eligibility for dental benefits, by completing an enrollment card and indicating your choice. If you do not make a selection within 90 days of your initial eligibility, you will automatically be enrolled in Dental Plan B. You will not be allowed to change dental plans until the next open enrollment period. Each year the Trust will hold an open enrollment period during which time you may select a new dental plan option.

BRIEF OVERVIEW OF BENEFITS

The following is a partial listing of benefits provided by each dental plan. All benefits provided by Dental Plan A and Dental Plan B are subject to the limitations and exclusions listed separately for each Plan in the official Plan booklet. This summary is intended only to provide a sample listing of applicable co-pays for Dental Plan A and Dental Plan B schedule of benefits for some common dental procedures. To obtain a copy of the Plan booklet, please contact the Trust office at (206)-282-3600 or toll free at (800)-826-2102, Option #2 then Option #2 again at the second prompt.

DENTAL PLAN A

WILLAMETTE DENTAL OF WASHINGTON INC., is a network of dental clinics in Washington, Oregon and Idaho that provides dental care to enrolled participants and their eligible dependents. If you select Dental Plan A for your dental benefits, you must receive your dental care at one of the Willamette Dental network clinics. Family members do not have to use the same Willamette Dental clinic. The co-pay represents your out of pocket expense for the dental services received and must be paid at the time of treatment.

The following represents your out of pocket expense for each procedure listed. A complete listing of procedures and co-pays is on file with the Trust office. Please refer to the Plan Booklet for a complete listing of Dental Plan A limitations and exclusions. To see a complete listing of the Willamette Dental clinics and phone numbers, please visit Willamettedental.com or call Willamette Dental at (855)-433-6825.

BENEFIT CATEGORY	CO-PAY
OFFICE VISIT	$ 15.00
Emergency Treatment (after hours)	$ 25.00
DIAGNOSTIC/ROUTINE/PREVENTIVE/BASIC SERVICES	No co-pay
Exams, Cleaning, Fluoride Treatments, X-rays, Sealants, Space Maintainers, Periodontal scale/prophy, minor restorations	
ORAL SURGERY	
Routine extractions	No co-pay
Extraction soft tissue, partial and full bony impaction (per tooth)	$ 100.00
PROSTHETICS	
Stainless Crown, primary	No co-pay
Metal or porcelain crowns or 3⁄4 crowns	$ 250.00
Upper or lower dentures, full or partial	$ 300.00
ENDODONTICS	
Anterior root canal	$ 75.00
Bicuspid root canal	$ 150.00
Molar root canal	$ 225.00
GENERAL ANESTHESIA	
First 30 minutes	$ 100.00
ORTHODONTICS	
Class 1, Class 2 and Class 3	$2800.00

DENTAL PLAN B

Dental Plan B is administered by Delta Dental of Washington. The following is a partial listing of scheduled benefit allowances. If you choose Dental Plan B, you may go to any dentist and you will be reimbursed according to the schedule listed below up to a maximum benefit of $2,000 per calendar year. The $2,000 annual maximum does not apply to orthodontics or Preventative and Minor Restorations for dependent children under the age of 18. Under Dental Plan B, your out-of-pocket will be the difference between the charge made by the dentist and the scheduled allowance. For a complete listing of benefits, limitations and exclusions please refer to the official Plan booklet. You will save money when you choose a dentist who is in the Delta Dental network because the dentists in the network charge a discounted rate for dental services. For a complete listing of benefits, limitations and exclusions please refer to the official Plan booklet, or call Delta Dental of Washington at 206-522-2300 or 800-554-1907.

BENEFIT CATEGORY	SCHEDULED BENEFIT
PROCEDURE/DIAGNOSTIC	
Examinations (two per year) Periodic oral exam	$ 45.00
Complete mouth intraoral x-rays, including bitewings (once each calendar year)	$ 104.00
Bitewing x-rays - two films	$ 35.00
PREVENTATIVE	
Prophy (cleaning and scaling) (two each calendar year) age 14 and over	$ 89.00
MINOR RESTORATIONS	
Amalgam - two surface	$ 120.00
Composite resin - two surface	$ 138.00
MAJOR RESTORATIONS	
Crown - Porcelain with metal (gold)	$ 658.00
Crown – Gold	$ 651.00
ENDODONTICS	
Pulpotomy	$ 103.00
Root Canal – includes entire treatment plan except final restoration - Bicuspid	$ 663.00
PERIODONTICS	
Periodontal maintenance (limited to one every 3 months)	$ 118.00
ORAL SURGERY	
Extractions (includes local anesthesia and routine post-operative care)	
Single tooth (uncomplicated)	$ 106.00
Erupted tooth (surgically removed)	$ 201.00
Impacted tooth – soft tissue	$ 205.00
PROSTHODONTICS	
Complete upper dentures	$1121.00
Complete lower dentures	$1015.00
Bridgework/porcelain fused to gold pontic	$ 667.00
OTHER DENTAL PROCEDURES	
General Anesthesia, first 30 minutes	$ 276.00
Space Maintainers/fixed, band type	$ 221.00
ORTHODONTICS	
50% of the allowable cost, up to a lifetime maximum of $2,000. Benefits paid under the Orthodontic benefit do not apply to the annual maximum of $2,000.	$2,000.00

Summary Of Vision Care Benefits

The Northwest Laborers-Employers Health & Security Trust contracts with VSP to provide you with an affordable eye care plan. Once you meet the eligibility requirements for Vision Care Benefits, the Medical Plan for Active eligible participants allows benefits for one well vision exam and one pair of prescription lenses each calendar year; frames are allowed every other year. VSP handles ALL vision claims. If you do not use a VSP provider, claims must be submitted to VSP for processing. Your out-of-pocket will be greater if you use a non-VSP provider.

For questions about the Vision Care Benefits or the use of non-VSP providers, visit VSP.com or call (800)-877-7195.

COVERAGE WITH A VSP DOCTOR	CO-PAY
WELL VISION EXAM	
One each calendar year	$10
PRESCRIPTION LENSES	
One set (2 lenses) each calendar year single vision, lined bifocal & lined trifocal lenses	No co-pay
Polycarbonate lenses for dependent children	No co-pay
* 35-40% savings on all non-covered lens options	
FRAMES	
One every other calendar year allowance $130 allowance for a wide selection of frames 20% off the amount over your allowance.	No co-pay up to $130
- OR –	
CONTACT LENSES	
One pair each calendar year ($130 allowance for contacts and the contact lens exam)	No co-pay up to $130 allowance

NOTE: ***If you choose contact lenses you will be eligible for a frame benefit one calendar year from the date the contact lenses were obtained.***

SUMMARY OF ACTIVE HOUR BANK ELIGIBILITY RULES

- Eligibility is determined on the basis of an hour bank system.
- For initial eligibility for ***medical and prescription drug coverage*****,** a minimum of 350 hours must be accumulated in a six month period. If 350 hours are not accumulated in the first six months of Covered Employment, the Trust will look to subsequent six month periods until the 350 hour requirement is met.
- Initial eligibility will be effective the first day of the second month following the accrual of 350 hours.
- Once the minimum eligibility requirement has been established, 300 hours will be deducted for the first month of eligibility and 130 hours will be deducted from the employee's hour bank for each subsequent month of coverage.
- For initial eligibility for ***dental, vision, time loss and life and personal loss*** **coverage,** a minimum of 1,000 hours is required in the hour bank (prior to deduction of hours for medical and prescription drug coverage). Coverage for dental, vision, time loss, life and personal loss will become effective on the first day of the second month following accumulation of the 1,000 hours.
- An employee will continue to be covered as long as there are 130 hours or more in the hour bank.
- A maximum hour bank of six consecutive months of prepaid continuous coverage (780 hours) can be accumulated.
- If the hours in the hour bank drop below 130 they remain in the hour bank for 10 months from the last date of eligibility, after which the hour bank will be forfeited. In the event the hour bank is forfeited, an employee will again become eligible upon completion of the initial eligibility requirement for new employees as noted above.

DISCLAIMER

This Benefits at a Glance provides general information about the Northwest Laborers-Employers Health & Security Trust. For more information please refer to the Plan Booklet and benefits updates that are available at www.zenith-american.com or by calling Zenith American Solutions. For questions about Dental Plan B, contact Delta Dental of Washington at 800-554-1907. In the event of conflicting information, the Plan Document and the Plan Booklet will govern. Trust Office - 206-282-3600 or toll free 800-826-2102

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