Massachusetts Laborers' Benefit Funds

Health & Welfare Plan Reference Guide

Overview of Plan A and Plan B Benefit Plans

Not sure which plan you qualify for? Check your eligibility.

1 **Medical Benefits**

2 **Mental Health Benefits**

2 **Substance Abuse Benefits**

4 **Dental Benefits**

5 **Prescription Drug Benefits**

6 **Vision Plan Benefits**

This information is intended only to provide highlights of the plans. In the event of any inconsistency between the information on this document and the official plan document, the terms of the official plan document, as interpreted by the Board of Trustees in its sole discretion, will control. All examples included in this document are not a guarantee of future benefits under the plans. The benefit amounts are estimates only, based on the stated assumptions and are subject to change. The Massachusetts Laborers Benefit Funds reserve the right to amend, modify, or terminate all or part of any plan at any time.

MEDICAL BENEFITS

	Plan A		Plan B	
	Network	**Non-Network**	**Network**	**Non-Network**
Annual deductible	$250 per individual; $500 per family per calendar year	No coverage	$500 per individual $1,000 per family per calendar year	No coverage
Hospital – Inpatient	Per admission: Fund pays 100% of the first $20,000 plus 85% of the excess charges with an out-of-pocket maximum of $2,000 (after deductible)	No coverage	Per admission: Fund pays 100% of the first $7,500 plus 85% of the excess charges with an out-of-pocket maximum of $5,000 (after deductible)	No coverage
Hospital – Outpatient	Fund pays 100% of the first $20,000 plus 85% of the excess charges with an out-of-pocket maximum of $2,000 (after deductible)	No coverage	Fund pays 90% after $30 copayment	No coverage
Urgent Care Facility	$20 copay	No coverage	$20 copay then Fund pays 90% of charges	No coverage
Physician	$20 primary care copay and $30 specialist copay	No coverage	Fund pays 90% after $30 copayment	No coverage
Annual physical exam (must be at least one year old)	Covered in full	Not covered	Covered in full	Not covered
	The Fund offers a $150 reimbursement per year for each member and spouse who has a routine physical and provides sufficient proof of at least four months of paid gym membership for the year the reimbursement is being requested			
Well baby care	Covered in full	Not covered	Covered in full	Not covered
Emergency treatment	Initial $20 physician copay then no cost after $150 additional facility copay for 1st 3 emergency visits /cal. yr. Thereafter $300 ER facility copay (copay waived if admitted)	Initial $20 physician copay then no cost after $150 additional facility copay for 1st 3 emergency visits / cal. yr. Thereafter $300 ER facility copay (copay waived if admitted; limited to R&C)	Initial $20 physician copay then no cost after $150 additional facility copay for 1st 3 emergency visits /cal. yr. Thereafter $300 ER facility copay (copay waived if admitted)	Initial $20 physician copay then no cost after $150 additional facility copay for 1st 3 emergency visits / cal. yr. Thereafter $300 ER facility copay (copay waived if admitted; limited to R&C)

MENTAL HEALTH CARE BENEFITS: Subject to deductible and applicable copayments

	Plan A		Plan B	
	Network	**Non-Network**	**Network**	**Non-Network**
Inpatient (Authorization from MAP required)	Fund pays 100% of the first $20,000 plus 85% of the excess charges with an out-of-pocket maximum of $2,000	Not covered	Fund pays 100% of the first $7,500 plus 85% of the excess charges with an out-of-pocket maximum of $5,000 per admission	Not covered
Outpatient	Fund pays 100% after $20 copay	Not covered	Fund pays 100% after $20 copay	Not covered

SUBSTANCE ABUSE BENEFITS: Subject to deductible

	Plan A		Plan B	
	Network	**Non-Network**	**Network**	**Non-Network**
Inpatient	Paid the same as inpatient mental health care		Paid the same as inpatient mental health care	
Outpatient	Covered in full	Not covered	Fund pays 90% of covered charges after $20 copay	Not covered

DENTAL BENEFITS

	Plan A		Plan B	
	Network	**Non-Network**	**Network**	**Non-Network**
Type I (Diagnostic and Preventive Benefits: exams, cleanings, etc.)	100%	100% of usual and customary charges	100%	100% of usual and customary charges
Type II (Restorative and Other Basic Services: fillings and crowns, etc.)	80%	80% of usual and customary charges	None	
Type III (Major Restorative Services: crowns, dentures and bridges, etc.)	50%	50% of usual and customary charges	None	
Annual Maximum	None		None	
Orthodontia	Lifetime maximum of $2,500, available up to age 19		None	

PRESCRIPTION DRUG BENEFITS (Express Scripts)

	Plan A and Plan B
	Network and Non-Network
Prescription filled through the Plan's 30-day supply at a retail pharmacy	You pay the following co-payment per prescription for up to a 30-day supply: ○ Generic drug: $10 ○ Preferred brand-name: $30 ○ Non-preferred brand-name: $50 Beneficiaries are now responsible for 100% of the cost if you fill a 30-day script at a retail pharmacy beyond the third fill.
Prescription filled through the plan's 90-day supplies program (available through CVS retail pharmacy or mail order)	You pay the following copayment per prescription for up to a 90-day supply: ○ Generic drug: $10 ○ Preferred brand-name: $30 ○ Non-preferred brand-name: $50 The Fund covers the remaining cost.

***Prescription Drug Benefits coverage is identical for Network and Non-Network providers.**

VISION PLAN BENEFITS (Davis Vision)

	Davis Vision Plan
Preferred Provider	If you use a participating Davis Vision provider, you will not have to pay anything. Locate a Davis Vision Provider at DavisVision.com
Coverage	∘ Glass or plastic single vision, bifocal or trifocal lenses (You may select two complete pairs of eyeglasses, one for near vision, one for distance vision, in lieu of receiving a bifocal) ∘ Oversize and over diopter (high power) lenses ∘ PGX (photosensitive) glass lenses ∘ Glass grey #3 prescription sunglasses lenses ∘ Progressive addition lenses ∘ Supershield coating for both single vision and multifocal lenses ∘ Polycarbonate lenses for children and monocular patients ∘ Lasik surgery The Davis Vision provider will provide detailed information about the options that are available to you under this Plan. (see Summary Plan Description for exceptions).
Filing a claim	No claims required