WASHINGTON TEAMSTERS WELFARE TRUST

Medical Plans Comparison – 2010 – WaTWT Plans A and B to Pierce County's Regence Preferred Plan FourFront $500, Preferred Plan 100/90/60/20, and Selections 90/60/20

This summary is not intended to be an all-inclusive description of Plan benefits and does not cover all limitations or exclusions. This summary should not be used in lieu of a Plan booklet. While every effort has been made to ensure that the information is accurate, if there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets govern.

	Regence Preferred FourFront $500	Regence Preferred 100/90/60/20	Regence Selections 90/60/20	WaTWT Plan A	WaTWT Plan B
Major Features					
Monthly Contribution Rate				**$933.00 –** Full Family	**$840.10 –** Full Family
Copayments Office Visits ER Visits Hospital	**$15** per office visit **$75** per ER visit (waived if admitted) **None**	**$20** per visit **$100** per ER visit or outpatient surgery (waived if admitted) **$150** per inpatient stay	**$20** per visit **$100** per ER visit or outpatient surgery (waived if admitted) **$150** per day; **$450** maximum	**$15** per office visit **$75** per ER visit (waived if admitted) **None**	**$20** per office visit **$75** per ER visit (waived if admitted) **None**
Calendar Year Deductible	**$500** per person; **$1,500** per family Does not apply to first four office visits or first $500 outpatient x-ray and lab	**$300** per person; **$900** per family Does not apply to preventive care	**$150** per person; **$300** per person; **$450** per family **$900** per family Does not apply to preventive care.	**$100** per person; **$300** per family Does not apply to outpatient professional visits that are subject to per visit copays.	**$250** per person; **$750** per family Does not apply to outpatient professional visits that are subject to per visit copays.
Calendar Year Co-insurance Out-of-Pocket Maximum	**$2,500** per person; maximum **$7,500** per family**	**$2,500** per person; maximum **$7,500** per family**	**$1,500** per person; maximum **$4,500** per family**	**$500** per person; maximum **$1,000** per family*	**$1,500** per person; maximum **$3,000** per family*
Coinsurance (applies to most benefits)	**80%** for PPO Providers **50%** for Participating Providers	**100/90%** for PPO Providers **60%** for Participating Providers	**90%** for PPO Providers **60%** for Participating Providers	**90%**	**80%**
Lifetime Maximum	$2,000,000 per person	$2,000,000 per person	$2,000,000 per person	$2,000,000 per person	$2,000,000 per person
Medical Provider Network	Regence Blue Shield	Regence Blue Shield	Regence Blue Shield/Asuris NW	First Choice Health WA OR ID MT AK Beech Street in all other states	First Choice Health WA OR ID MT AK Beech Street in all other states
Coordination of Benefits (COB)				Standard Coordination.	Standard Coordination.
Dependent Children				Through age 18 or full-time students through age 25 or disabled.	Through age 18 or full-time students through age 25 or disabled.
Hospital and Emergency Room Benefits					
	Preferred Providers **Participating Providers**	**Preferred Providers** **Participating Providers**	**Preferred Providers** **Participating Providers**	**All Providers**	**All Providers**
Emergency Room Care	80% after deductible 50% after deductible And after $75 copay per visit (waived if admitted)	90% after deductible 60% after deductible And after $100 copay per visit (waived if admitted)	90% after deductible 60% after deductible And after $100 copay per visit (waived if admitted)	90% after the deductible And after $75 copay per visit (waived if admitted)	80% after the deductible And after $75 copay per visit (waived if admitted)
Hospital Inpatient Pre-certification	Pre-certification required for services outside the service area.	Pre-certification required for services outside the service area.	Pre-certification required for services outside the service area.	Pre-certification required; $200 copay when admission not pre-certified. No coverage at non-PPO hospital for days not certified by Qualis Health as medically necessary	Pre-certification required; $200 copay when admission not pre-certified. No coverage at non-PPO hospital for days not certified by Qualis Health as medically necessary
Hospital Charges (inpatient and outpatient)	80% after deductible 50% after deductible	90% after deductible and $150 copay per stay 60% after deductible and $150 copay per stay	90% after deductible and $150 copay per day; $450 max 60% after deductible and $150 copay per day; $450 max	90% after the deductible	80% after the deductible

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Physician Services					
	First four visits per year no deductible: 100% after $15 copay 50% after $15 copay ***After first four visits:***				
Professional Services	80% after $15 copay per visit and deductible 50% after $15 copay per visit and deductible	100% after $20 copay per visit and deductible 60% after $20 copay per visit and deductible	90% after $20 copay per visit and deductible 60% after $20 copay per visit and deductible	90% after the deductible	80% after the deductible
Office Visits	80% after $15 copay per visit and deductible 50% after $15 copay per visit and deductible	100% after $20 copay per visit and deductible 60% after $20 copay per visit and deductible	90% after $20 copay per visit and deductible 60% after $20 copay per visit and deductible	100% after $15 copay per visit	100% after $20 copay per visit
Preventive Care	80% after $15 copay per visit and deductible 50% after $15 copay per visit and deductible	100% after $20 copay per visit Not covered Maximum $300 per person per year	90% after $20 copay per visit Not covered	100% after $15 copay per visit	100% after $20 copay per visit
Other Plan Benefits					
Diagnostic X-Ray/Lab	80% after deductible 50% after deductible No deductible for first $500 per year	100% after $20 copay per visit and deductible 60% after $20 copay per visit and deductible	90% after deductible 60% after deductible	90% after the deductible	80% after the deductible
Alternative Treatment Settings, in lieu of Hospitalization	80% after deductible 50% after deductible	90% after deductible 60% after deductible	90% after deductible 60% after deductible	90% after the deductible	80% after the deductible
Home Health Care	Maximum 130 visits per calendar year	Maximum 130 visits per calendar year	Maximum 130 visits per calendar year	Maximum 130 visits per calendar year	Maximum 130 visits per calendar year
Hospice Care	Maximum 6 months	Maximum 6 months	Maximum 6 months	Maximum of $10,000 lifetime	Maximum of $10,000 lifetime
Skilled Nursing Facility	Maximum 90 days per calendar year	Maximum 90 days per calendar year	Maximum of 90 days per calendar year	Up to $100 per day, maximum 180 days	Up to $100 per day, maximum 180 days
Home Medical Equipment	80% after deductible 50% after deductible	90% after deductible 60% after deductible	90% after deductible 60% after deductible	90% after deductible	80% after deductible
Special Equipment	80% after deductible 50% after deductible	100% after deductible 100% after deductible	100% after deductible 60% after deductible	90% after deductible	80% after deductible
Hearing Aids				90% after the deductible up to $1,000 maximum per ear per person every 36 months. Cochlear implants covered under regular benefits	80% after the deductible up to $1,000 maximum per ear per person every 36 months. Cochlear implants covered under regular benefits
Jaw Treatment (including TMJ and MPD)	80% after deductible 50% after deductible TMJ maximum $1,000 per calendar year; maximum $5,000 lifetime	90% after deductible 60% after deductible TMJ maximum $1,000 per calendar year; maximum $5,000 lifetime	50% after deductible 50% after deductible TMJ maximum $1,000 per calendar year; maximum $5,000 lifetime	90% after the deductible, up to $6,000 lifetime per person	80% after the deductible, up to $6,000 lifetime per person
Ambulance	80% after deductible 80% after deductible	80% after deductible 80% after deductible	80% after deductible 80% after deductible	90% after deductible	80% after deductible
Organ Transplants	80% after deductible 50% after deductible $250,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum. Covered after six month waiting period.	100% professional 60% 90% facility 60% After applicable copay or deductible. $250,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum. Covered after six month waiting period.	90% after deductible Not covered $250,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum. Covered after six month waiting period.	Special rules and limits apply. $200,000 maximum for confinement charges (per confinement). Covered after six month waiting period.	Special rules and limits apply. $200,000 maximum for confinement charges (per confinement). Covered after six month waiting period.

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Inpatient Rehabilitation	80% after deductible 50% after deductible Maximum $30,000 per condition	100% professional 60% 90% facility 60% After applicable copay or deductible. Maximum $50,000 per condition	90% after deductible 60% after deductible Maximum of $50,000 per condition.	90% after the deductible	80% after the deductible
Outpatient Physical Therapy Occupational Therapy Speech Therapy	80% after deductible 50% after deductible Maximum $1,500 per calendar year	100% professional 60% 90% facility 60% After applicable copay or deductible. Maximum $1,500 per calendar year	90% after deductible and $20 copay 60% after deductible and 420 copay Max of $1,500 per year.	100% after $15 copay per visit, maximum of 24 visits of each therapy per person per calendar year	100% after $20 copay per visit, Maximum 24 physical therapy visits and 24 occupational therapy visits per person per calendar year; 60 vision therapy visits per person per lifetime
Spinal Treatment	80% after deductible 50% after deductible Maximum 10 manipulations per calendar year	100% after deductible and $20 copay 60% after deductible and $20 copay Maximum 12 manipulations per calendar year	90% after deductible and $20 copay 60% after deductible and $20 copay Maximum 15 manipulations per calendar year	100% after $15 copay per visit, maximum of 15 visits per person per calendar year	100% after $20 copay per visit, maximum of 15 visits per person per calendar year
Acupuncture Treatment	80% after deductible 50% after deductible Maximum 12 visits per calendar year	100% after and deductible 60% after and deductible Maximum 12 visits per calendar year	90% after $20 copay and deductible 60% after $20 copay and deductible Maximum 12 visits per calendar year	100% after $15 copay per visit, maximum of 15 visits per person per calendar year, only covered if a PPO provider is used	100% after $20 copay per visit, maximum of 15 visits per person per calendar year, only covered if a PPO provider is used
Massage Therapy				100% after $15 copay, maximum 12 visits per person per calendar year. Must be prescribed by physician for diagnosed medical condition.	100% after $20 copay, maximum 12 visits per person per calendar year. Must be prescribed by physician for diagnosed medical condition.
Naturopathic Treatment Therapy				100% after $15 copay, maximum 2 visits per person per calendar year. Must use PPO provider; visits only not supplies, etc.	100% after $20 copay, maximum 2 visits per person per calendar year. Must use PPO provider; visits only not supplies, etc.
Employee Assistance Program (EAP)				Provided by MHN. 100% of MHN authorized network charges. Up to 3 visits per person per year	Provided by MHN. 100% of MHN authorized network charges. Up to 3 visits per person per year
Mental Health	80% after deductible 50% after deductible Inpatient maximum 8 days per calendar year; outpatient maximum 12 visits per calendar year	100% professional 60% 90% facility 60% Inpatient maximum 8 days per calendar year; outpatient maximum 45 visits per calendar year	90% after deductible 60% after deductible Maximum 12 days inpatient per calendar year; outpatient maximum 45 visits per calendar year	Provided by MHN. 100% of MHN authorized network charges or 50% of UCR for authorized non-network charges. Outpatient copays of $5-$15 per session. Outpatient maximum 50 visits per person per year; Inpatient maximum 45 inpatient days per person per year, lifetime maximum 90 days.	Provided by MHN. 100% of MHN authorized network charges or 50% of UCR for authorized non-network charges. Outpatient copays of $5-$15 per session. Outpatient maximum 50 visits per person per year; Inpatient maximum 45 inpatient days per person per year, lifetime maximum 90 days.
Substance Abuse	80% after deductible 50% after deductible Maximum $14,500 every two calendar years.	100% after deductible 60% after deductible $150 copay per inpatient stay. Maximum $14,500 every two calendar years.	90% after deductible 60% after deductible $150 copay per inpatient day; $450 maximum copay. Maximum $14,500 every two calendar years.	Provided by MHN. 100% of MHN authorized network charges or 50% of UCR for authorized non-network charges. Substance abuse maximums of $10,000 per episode and 2 episodes per lifetime.	Provided by MHN. 100% of MHN authorized network charges or 50% of UCR for authorized non-network charges. Substance abuse maximums of $10,000 per episode and 2 episodes per lifetime.

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Weight-Loss Program and Obesity Surgery				Surgical and Non-Surgical programs available through Sound Health Solutions for qualified individuals. Plan pays straight 80%. Deductible and out-pocket-maximum do not apply.		Surgical and Non-Surgical programs available through Sound Health Solutions for qualified individuals. Plan pays straight 80%. Deductible and out-pocket-maximum do not apply.	
Tobacco Cessation	75% after deductible 75% after deductible Maximum $500 lifetime	75% after deductible 75% after deductible Maximum $500 lifetime	80% after deductible 80% after deductible Maximum $500 lifetime	Coaching program and nicotine replacement therapy (NRT) provided at no cost. Prescription medications subject to regular copays and maximums of $500 per calendar year; $1,000 per lifetime. Must be enrolled in the Trust's coaching program through StayWell to get NRT or prescription coverage.		Coaching program and nicotine replacement therapy (NRT) provided at no cost. Prescription medications subject to regular copays and maximums of $500 per calendar year; $1000 per lifetime. Must be enrolled in the Trust's coaching program through StayWell to get NRT or prescription coverage.	
Wellness Programs				Plan may from time to time offer personal health assessments and incentives to work with a health coach if certain health risks or chronic conditions are identified. Health and wellness coaching is covered at 100%.		Plan may from time to time offer personal health assessments and incentives to work with a health coach if certain health risks or chronic conditions are identified. Health and wellness coaching is covered at 100%.	
Prescription Drugs							
	Up to 34-day supply	Participating Pharmacy	Participating Pharmacy	Up to 34-day supply		Up to 34-day supply	
Retail Network Pharmacy	Participating Pharmacy	$10 copay	$10 copay	Recommended Network Pharmacy	Regular Network Pharmacy	Recommended Network Pharmacy	Regular Network Pharmacy
Generic	$10 copay	$20 copay	$20 copay	Copay of $5 or 10%, whichever is larger	Copay of $10 or 10%, whichever is larger	Copay of $5 or 10%, whichever is larger	Copay of $10 or 10%, whichever is larger
Brand Formulary	$20 copay	$40 copay	$40 copay	Copay of $15 or 30%, whichever is larger	Copay of $20 or 30%, whichever is larger	Copay of $15 or 30%, whichever is larger	Copay of $20 or 30%, whichever is larger
Brand Non-Formulary	$40 copay	Not covered	Not covered	Copay of $15 or 30%, whichever is larger	Copay of $20 or 30%, whichever is larger	Copay of $15 or 30%, whichever is larger	Copay of $20 or 30%, whichever is larger
Retail Non-Network	Not covered			Not Covered except in a medical emergency		Not Covered except in a medical emergency	
Mail Order Network Pharmacy	Up to 90-day supply	Up to 90-day supply	Up to 90-day supply	Up to a 100-day supply		Up to a 100-day supply	
Generic	$10 copay	$10 copay	$10 copay	$10 copay		$10 copay	
Brand Formulary	$20 copay	$20 copay	$20 copay	$35 copay		$35 copay	
Brand Non-Formulary	$40 copay	$40 copay	$40 copay	$35 copay		$35 copay	
Ancillary Benefits							
Disability Waivers (extension of coverage)				3 months included. Additional 9 months may be added.		3 months included. Additional 9 months may be added.	
Nurse Advice Line	24/7	24/7	24/7	24/7		24/7	
Routine Vision Exam and Hardware	Included	Included	Included	Covered under separate vision plan		Covered under separate vision plan	

*Excludes copays and deductible, cost sharing for mental health, substance abuse, weight-loss program, prescription drugs, and non-covered expenses.
** Excludes copays, cost sharing for neurodevelopmental therapy, repair of teeth, prescription drugs, outpatient rehabilitation, smoking cessation, and non-covered expenses.

Ancillary Benefit Add-ons for WaTWT Medical Plans		Monthly Rate
Life Plan A	$30,000 employee/$3,000 dependent	$ 8.60
Life Plan B	$15,000 employee/$1,500 dependent	$ 4.40
Life Plan C	$ 5,000 employee/$ 500 dependent	$ 1.60
Additional 9 Month Disability Waiver		
9 month disability waiver		$ 11.40
Timeloss – Employee only		
Time Loss Plan A	Weekly benefit: $400	$ 19.50
Time Loss Plan B	Weekly benefit: $300	$ 10.50
Time Loss Plan C	Weekly benefit: $200	$ 6.50
Time Loss Plan D	Weekly benefit: $100	$ 3.00
Domestic Partners		
		$ 14.00