

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								
Copayments								
Office Visits	\$15 per office visit		\$20 per visit		\$20 per visit		\$15 per office visit	\$20 per office visit
ER Visits	\$75 per ER visit (waived if admitted)		\$100 per ER visit or outpatient surgery (waived if admitted)		\$100 per ER visit or outpatient surgery (waived if admitted)		\$75 per ER visit (waived if admitted)	\$75 per ER visit (waived if admitted)
Hospital	None		\$150 per inpatient stay		\$150 per day; \$450 maximum		None	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 And after \$75 copay per visit (waived if admitted)	50% after deductible	90% after deductible And after \$100 copay per visit (waived if admitted)	60% after deductible	90% after deductible And after \$100 copay per visit (waived if admitted)	60% after deductible	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 50% after \$15 copay \$15 copay <i>After first four visits:</i>							
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 Maximum \$300 per person per year	Not covered	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 No deductible for first \$500 per year	50% after deductible	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 TMJ maximum \$1,000 per calendar year; maximum \$5,000 lifetime	50% after deductible	90% after deductible TMJ maximum \$1,000 per calendar year; maximum \$5,000 lifetime	60% after deductible	50% after deductible TMJ maximum \$1,000 per calendar year; maximum \$5,000 lifetime	50% after deductible	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 \$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.	50% after deductible	100% professional 90% facility 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.	60% 60%	90% 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.	Not covered	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	100% professional 90% facility	60% 60%	90% after deductible	60% after deductible	90% after the deductible	80% after the deductible
	Maximum \$30,000 per condition		After applicable copay or deductible. Maximum \$50,000 per condition		Maximum of \$50,000 per condition.			
Outpatient Physical Therapy Occupational Therapy Speech Therapy	80% after deductible	50% after deductible	100% professional 90% facility	60% 60%	90% after deductible and \$20 copay	60% after deductible and 420 copay	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
	Maximum \$1,500 per calendar year		After applicable copay or deductible. Maximum \$1,500 per calendar year		Max of \$1,500 per year.			
Spinal Treatment	80% after deductible	50% after deductible	100% after deductible and \$20 copay	60% after deductible and \$20 copay	90% after deductible and \$20 copay	60% after deductible and \$20 copay	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
	Maximum 10 manipulations per calendar year		Maximum 12 manipulations per calendar year		Maximum 15 manipulations per calendar year			
Acupuncture Treatment	80% after deductible	50% after deductible	100% after deductible and deductible	60% after deductible and deductible	90% after \$20 copay and deductible	60% after \$20 copay and deductible	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
	Maximum 12 visits per calendar year		Maximum 12 visits per calendar year		Maximum 12 visits per calendar year			
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	100% professional 90% facility	60% 60%	90% after deductible	60% after deductible	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.
	Inpatient maximum 8 days per calendar year; outpatient maximum 12 visits per calendar year		Inpatient maximum 8 days per calendar year; outpatient maximum 45 visits per calendar year		Maximum 12 days inpatient per calendar year; outpatient maximum 45 visits per calendar year			
Substance Abuse	80% after deductible	50% after deductible	100% after deductible	60% after deductible	90% after deductible	60% after deductible	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.
	Maximum \$14,500 every two calendar years.		\$150 copay per inpatient stay. Maximum \$14,500 every two calendar years.		\$150 copay per inpatient day; \$450 maximum copay. Maximum \$14,500 every two calendar years.			

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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 Maximum \$500 lifetime	75% after deductible Maximum \$500 lifetime	75% after deductible Maximum \$500 lifetime	75% after deductible Maximum \$500 lifetime	80% after deductible Maximum \$500 lifetime	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 \$10 copay		Participating Pharmacy \$10 copay		Up to 34-day supply		Up to 34-day supply		
Retail Network Pharmacy							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.