WASHINGTON TEAMSTERS WELFARE TRUST

Medical Plan Comparison – 2007

Oak Harbor Freight Traditional and Preferred Plans vs. Medical Plan B

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.

	Oak Harbor Freight Regence BC/BS HDHP w/ HSA		Oak Harbor Freight Regence BC/BS Preferred Plan		WaTWT Medical Plan B
Major Features					
Monthly Contribution Rates	COBRA Rates Employee $422.41 Spouse $422.41 Spouse + 1 Child $718.10 Spouse + Children $718.10 1 Child $422.41 Children $718.10 Employee + Spouse $887.07 Employee, Spouse + 1 Child $1182.75 Employee, Spouse & Children $1182.75 Employee + 1 Child $718.10 Employee + Children $718.10		COBRA Rates Employee $484.34 Spouse $484.34 Spouse + 1 Child $823.37 Spouse + Children $823.37 1 Child $484.34 Children $823.37 Employee + Spouse $1017.11 Employee, Spouse + 1 Child $1356.15 Employee, Spouse & Children $1356.15 Employee + 1 Child $823.37 Employee + Children $823.37		**$698.90 –** Full Family ($725.40 for 2008) COBRA Rate $712.90 - Full Family ($739.90 for 2008)
	In-network	**Non network**	**In Network**	**Non Network**	**All Providers**
Office Visit Co-Pay	**NA**	**NA**	**$15**	**NA**	**$20**
Calendar Year Deductible	**$1,500** per person; to **$3,000** maximum per family (Aggregating deductible)		**$200** per person; to **$600** maximum per family		**$250** per person; to **$750** maximum per family **
Coinsurance	**80%**		**80%**	**60%**	**80%**
Co-Insurance Out-of-Pocket Maximum	**$3,500** per person; to **$7,000** maximum per family* (includes deductible)		**$1,250** per person; to **$3,750** maximum per family*(in network) $2,000,per person; to $6,000 max per family*(non network)		**$1,500** per person; to **$3,000** maximum per family****
Lifetime Maximum	**$1,000,000** per person		**$1,000,000** per person		**$2,000,000** per person
Medical Provider Network	Regence Blue Cross Blue Shield		Regence Blue Cross Blue Shield		Beech Street/First Choice
Hospital and Emergency Room					
Hospital Pre-certification and Utilization Review	Required for inpatient stays and outpatient surgeries; $250 penalty when admission not pre-certified.		Required for inpatient stays and outpatient surgeries; $250 penalty when admission not pre-certified.		Required for inpatient stays; $200 penalty when admission not pre-certified. No coverage for days not certified as medically necessary at non-PPO facility.
Emergency Room	80% after the deductible		100% after $75 copay (copay waived if admitted)	60% after the deductible	80% after the deductible and **$75** copay per visit (copay waived if admitted)
Hospital Charges	80% after the deductible	60% after deductible	80% after the deductible	$250 copay per visit then 60% after the deductible	80% after the deductible
Physician Services					
Office Visits	80% after the deductible	60% after the deductible	100% after $15 copay per visit. Not subject to deductible.	60% after the deductible	100% after $20 copay per visit. Not subject to deductible.
Preventive Care	100%. No deductible, unlimited		100%. No deductible, $500/yr. Max	60% after the deductible	100% after $20 copay per visit (includes exam and routine lab and x-ray)
					Up to $500 per person per calendar year

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Surgery and Other Professional Services	80% after the deductible		80% after the deductible	60% after the deductible	80% after the deductible
Other Plan Benefits					
Alternative Treatment Settings, in lieu of Hospitalization	80% after the deductible				80% after the deductible
Home Health Care	Up to 130 visits per calendar year		Up to 130 visits per calendar year, 100% before deductible		Up to 130 visits per calendar year
Hospice Care	Maximum of 6 months lifetime		Maximum of 6 months lifetime, 80% after deductible		Maximum of $10,000 lifetime
Skilled Nursing Facility	Up to 90 days per calendar year		Up to 90 days per calendar year, 100% before deductible		Up to $100 per day and 180 days per condition
Ambulance	80% after the deductible		80% after the deductible		80% after the deductible
Durable Medical Equipment	80% after the deductible		80% after the deductible		80% after the deductible
					All Providers
Diagnostic X-Ray/Lab	80% after the deductible	60% after the deductible	80% after the deductible	60% after the deductible	80% after the deductible
Inpatient Rehabilitation	80% after the deductible		80% after the deductible	$250 copay then 60% after the deductible	80% after the deductible
Outpatient Physical or Occupational Therapy	80% after the deductible		80% after the deductible		100% after $20 copay per visit.
					Maximum of 24 visits of each therapy per person per calendar year
Speech Therapy	Information not found (maybe covered under Neurodevelopmental benefit)		Information not found(maybe covered under Neurodevelopmental benefit)	Information not found(maybe covered under Neurodevelopmental benefit)	100% after $20 copay per visit
					Maximum of 60 visits per lifetime
Massage Therapy	Not covered		Not covered	Not covered	100% after $20 copay per visit
					Maximum 12 visits per person per calendar year.
Organ Transplants	$25,000 maximum for donor benefits; $5,000 maximum for transportation expenses.		$25,000 maximum for donor benefits; $5,000 maximum for transportation expenses.		$200,000 maximum for inpatient services per confinement. No limit on outpatient services. Covered after 6 continuous months in plan.
Spinal Treatment	80% after the deductible		80% after the deductible		100% after $20 copay per visit; x-rays covered at 80% after deductible
					Maximum 15 visits and $100 x-rays per person per calendar year.
Acupuncture Treatment	In network; 80% after deductible Out of network; 60% after deductible		100% after $15 copay per visit	60% after deductible	100% after $20 copay per visit.
					Limited to 15 visits per person per calendar year. Acupuncturist must be a PPO provider
Mental Health - Inpatient	80% after the deductible	60% after deductible	80% after the deductible	$250 copay then 60% after the deductible	100% of authorized network charges or 50% for authorized non-network charges. No deductible.
	Limited to 10 days per calendar year and 20 days per lifetime.		Limited to 10 days per calendar year and 20 days per lifetime.		Limited to 45 days per calendar year and 90 days per lifetime.

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Outpatient	50% after the deductible	$15 Copay limited to $5,000 every 24 months, lifetime max $10,000	100% of authorized network charges or 50% for authorized non-network charges. No deductible.	
	Up to 50 visits per person per year.	Up to 50 visits per person per year.	Up to 50 visits per person per year.	
Substance Abuse Inpatient/ Outpatient	Inpatient: 80% after the deductible. Outpatient: 50% after the deductible. / Inpatient: 60% after the deductible. Outpatient: 50% after the deductible	Inpatient: 80% after the deductible. Outpatient: $15 then 100% after the deductible. / Inpatient: 60% after the deductible. Outpatient: $15 copay then 100% after the deductible.	100% of authorized network charges or 50% of authorized non-network charges. No deductible.	
	$5,000 every 24 months, $10,000 lifetime	$5,000 every 24 months, $10,000 lifetime	Limited to $10,000 per episode and 2 episodes per lifetime.	
Obesity Services	Coverage subject to treatment plans and approval	Coverage subject to treatment plans and approval	80% for covered non-surgical and surgical programs approved by Trust. Special rules.	
			All Providers	
Jaw Treatment (including TMJ and MPD)	$5,000 every 24 months, $10,000 lifetime	Office visit 100% after $15 copay; Hospital and care 80% after deductible / 60% after the deductible	80% after the deductible	
	$1,000 lifetime maximum per person for TMJ. Congenital defects not covered.	$1,000 lifetime maximum per person for TMJ. Congenital defects not covered.	$6,000 lifetime maximum per person. Maximum waived for congenital defects.	
Hearing Aids	Not covered	Not covered / Not covered	80% after the deductible to $500 per person every 3 calendar years. Cochlear implants covered under regular benefits. Max waived for children with congenital defects.	
Prescription Drugs				
Retail Network	Caremark Up to 34-day supply or 100 units	Caremark Up to 30-day supply or 100 units	NBN/Rx Up to 34-day supply	
			Recommended Pharmacy	**Regular Pharmacy**
Generic	80% after deductible	100% after $10 copay	100% after oopay equal to larger of $5 or 10%	100% after copay equal to larger of $10 or 10%
Formulary Brand	80% after deductible	100% after $25 copay	100% after copay equal to larger of $15 or 30%	100% after copay equal to larger of $20 or 30%
Non-Formulary Brand	80% after deductible	100% after $40 copay	100% after copay equal to larger of $15 or 30%	100% after copay equal to larger of $20 or 30%
Retail Non-Network Pharmacy	Not covered	Not covered	Not covered except in medical emergency	
Mail Order	Not Available	Coremark Mail Service. Up to a 90 day supply	Union Center Pharmacy. Up to a 100-day supply	
Generic	N/A	100% after $20 copay	100% after $10 copay	
Preferred Brand	N/A	100% after $50 copay	100% after $35 copay	
Non-Preferred Brand	N/A	100% after $80 copay	100% after $35 copay	
Contraceptives	Covered	Covered	Covered	
Smoking Cessation	80%. Limited to $500 per person per calendar year; $1,500 lifetime	80%. Limited to $500 per person per calendar year; $1,500 lifetime	Limited to $500 per person per calendar year; $1,000 lifetime	
Miscellaneous and Other Benefits				
Coordination of Benefits (COB)	Standard COB	Standard COB	Standard COB	

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Pre-existing Condition	3 month waiting period less any creditable coverage	3 month waiting period less any creditable coverage	No waiting period
Dependent Children	Up to age 19, and from 19 through age 24 if full-time student, any age if disabled.	Up to age 19, and from 19 through age 24 if full-time student, any age if disabled.	Up to age 19, and from 19 through age 25 if full-time student, any age if disabled.
Domestic Partners	Information not found	Information not found	Not included – Coverage available for bargaining and additional monthly contribution
Disability Extension of Coverage	Information not found	Information not found	3 months included. Additional 9 available.
Life/AD&D Insurance	$15,000 per employee	Information not found	Not included - Plan A, B or C available
Time Loss Benefits	Information not found	Information not found	Not included – Plan A, B, C or D available. 1st day coverage for accident. 1 week wait for illness. 26 weeks equivalent maximum.
Long Term Disability	Information not found	Information not found	Not included - LTD plan available. 6-month waiting period. 60% of wages offset by other disability income. Maximum five years and $1,500/mo. Minimum $50/mo.

* Excludes penalties and ineligible charges.

**Does not apply to office visits subject to copays, prescriptions, or mental health and chemical dependency.

*** Once an individual has reached their co-insurance out-of-pocket maximum during a calendar year, the plan pays most eligible expenses at 100% for the rest of that calendar year. Does not apply to some benefits, i.e. amounts exceeding allowed charges, charges for excluded services, non-notification penalties, prescriptions, deductibles or copays

Usual Customary and Reasonable (UCR) charge limits apply to non-network (non-PPO) healthcare providers and hospitals.

Ancillary Benefit Add-ons for WaTWT Medical Plans		Monthly Rate
Employee Life, AD&D and Dependent Life		
Plan A	$30,000 employee/$3,000 dependent	$ 9.40
Plan B	$15,000 employee/$1,500 dependent	$ 4.75
Plan C	$ 5,000 employee/$ 500 dependent	$ 1.70
Additional 9 Month Disability Waiver		
9 month disability waiver		$ 11.40
Timeloss – Employee only		
Time Loss Plan A	Weekly benefit: $400	$ 20.00
Time Loss Plan B	Weekly benefit: $300	$ 13.50
Time Loss Plan C	Weekly benefit: $200	$ 8.00
Time Loss Plan D	Weekly benefit: $100	$ 3.50
Long Term Disability		
Long Term Disability		$ 6.25