2020 Medical Plans Summary

	A5 Medical Plan Summary	A6 Medical Plan Summary	AV8 Medical Plan Summary	AV9 Medical Plan Summary
Composite Rate	**2020 - $1,376.00**	**2020 - $978.00**	**2020 - $ 994.00**	**2020 - $1,050**
Mixed or Tiered Rate	Mixed Rate Available Employee only - $757.00 Emp + Child(ren) - $1,437.00 Emp + Spouse - $1,514.00 Family - $2,271.00	Composite Rate Only	Composite Rate Only	Composite Rate Only
Managed Care Plan	No			
Waiting Period	No			
Pre-Existing Condition Exclusion	No			
Referral	Referrals are not required			
Coordination of Benefits	Yes			
Subrogation	Yes			
COBRA	Yes			
Precertification	Required for inpatient admissions and outpatient surgeries. $250 penalty if not pre-authorized.			
Waiver of Premium	3 months maximum			
Life Insurance Employee Dependents	 $5,000; $7,000 if accidental death $2,500 spouse; $1,000 children			
Pharmacy Network	MaxorPlus			
Provider PPO Network	Premera Blue Cross www.premera.com or 1-800-810-BLUE(2583)			
Type of Plan	PPO - Preferred Provider *and* Non-Preferred Provider			

This is only a summary of the key coverage provisions of the medical plans effective January 1, 2019 and is not intended to be used for general distribution purposes or in lieu of a Plan Booklet. If there are any discrepancies the plan booklet will govern.

Questions regarding these medical plans, please contact the Trust office at (253) 474-1214.

United Employees Benefit Trust
Non-Profit Provider of Employee Benefits Since 1965

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	Preferred Provider	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**
Annual Deductible								
Individual	$200		$300		$300		$300	
Family	$600		$900		$900		$900	
Office Visit copayment	$20		$25		$25		$25	
Individual Out of Pocket	10% up to the Annual Out of Pocket	30%	20% up to the Annual Out of Pocket	40%	20% up to the Annual Out of Pocket	40%	20% up to the Annual Out of Pocket	40%
Annual Out-Of-Pocket	$5,000 Individual $10,000 Family Includes PPO deductible, copayments and cost share	No Annual Maximum	$5,000 Individual $10,000 Family Includes PPO deductible, copayments and cost share	No Annual Maximum	$5,000 Individual $10,000 Family Includes PPO deductible, copayments and cost share	No Annual Maximum	$5,000 Individual $10,000 Family Includes PPO deductible, copayments and cost share	No Annual Maximum
Physician Services								
Office Visit	$20 copay, 90%	$20 copay, 70%	$25 copay, 80%	$25 copay, 60%	$25 copay, 80%	$25 copay, 60%	$25 copay, 100%	$25 copay, 60%
Other Physician Services	90%	70%	80%	60%	80%	60%	80%	60%
Preventative Care	100% no cost share	$20 copay, 70% not subject to deductible	100% no cost share	$25 copay, 60% not subject to deductible	100% no cost share	$25 copay, 60% not subject to deductible	100% no cost share	$25 copay, 60% not subject to deductible
Alternative Care	$20 copay, 90%	$20 copay, 70%	$25 copay, 80%	$25 copay, 60%	$25 copay, 80%	$25 copay, 60%	$25 copay, 100%	$25 copay, 60%
Naturopath Acupuncture Massage Therapist	maximum 24 visits per calendar year		maximum 24 visits per calendar year		maximum 24 visits per calendar year		maximum 24 visits per calendar year	
Therapy	$20 copay, 90%	$20 copay, 70%	$25 copay, 80%	$25 copay, 60%	$25 copay, 80%	$25 copay, 60%	$25 copay, 100%	$25 copay, 60%
PT, OT, speech, pain	maximum 48 visits per calendar year		maximum 48 visits per calendar year		maximum 48 visits per calendar year		maximum 48 visits per calendar year	
chemo, radiation	no visit limits		no visit limits		no visit limits		no visit limits	

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TMJ - Jaw Disorders	90% to $7,500 lifetime maximum	70% to $7,500 lifetime maximum	80% to $7,500 lifetime maximum	60% to $7,500 lifetime maximum	80% to $7,500 lifetime maximum	60% to $7,500 lifetime maximum	80% to $7,500 lifetime maximum	60% to $7,500 lifetime maximum
Maternity (includes Midwives)								
Member or spouse only	90%	70%	80%	60%	80%	60%	80%	60%
Ambulance	90%	90%	80%	80%	80%	80%	80%	80%
Diagnostic, X-ray & Lab	90%	70%	80%	60%	80%	60%	80%	60%
Hospital								
Inpatient or Outpatient	90%	70%	80%	60%	80%	60%	80%	60%
Emergency Room	$150 copay, 90%	$150 copay, 90%	$150 copay, 80%	$150 copay, 80%	$150 copay, 80%	$150 copay, 80%	$150 copay, 80%	$150 copay, 80%
Skilled Nursing Facility	90%, 120 days per condition	70%, 120 days per condition	80%, 120 days per condition	60%, 120 days per condition	80%, 120 days per condition	60%, 120 days per condition	80%, 120 days per condition	60%, 120 days per condition
Home Health Care	90% 120 visits per year	70% 120 visits per year	80% 120 visits per year	60% 120 visits per year	80% 120 visits per year	60% 120 visits per year	80% 120 visits per year	60% 120 visits per year
Hospice	90% 120 days lifetime	70% 120 days lifetime	80% 120 days lifetime	60% 120 days lifetime	80% 120 days lifetime	60% 120 days lifetime	80% 120 days lifetime	60% 120 days lifetime
Hearing Aid	100% limited to $1,000 per aid, every five years		100% limited to $1,000 per aid, every five years		100% limited to $1,000 per aid, every five years		100% limited to $1,000 per aid, every five years	
Prosthetic Devices	90%	70%	80%	60%	80%	60%	80%	60%
Durable Medical Equipment (DME)	90% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	70% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	80% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	60% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	80% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	60% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	80% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental	60% Pre-authorization required for DME over $2,000 purchase or $500 monthly rental
Organ Transplant	90% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	70% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants

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THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE DEDUCTIBLE, DO NOT APPLY TOWARDS THE ANNUAL OUT OF POCKET AND ARE LIMITED TO THE BENEFITS INDICATED.				
Chiropractic	$20 copay,100% one spinal exam per year; $100 for x-rays per year $20 copay, 100% up to 24 adjustments per year	$25 copay,100% one spinal exam per year; $100 for x-rays per year $25 copay, 100% up to 24 adjustments per year	$25 copay,100% one spinal exam per year; $100 for x-rays per year $25 copay, 100% up to 24 adjustments per year	$25 copay,100% one spinal exam per year; $100 for x-rays per year $25 copay, 100% up to 24 adjustments per year
Prescription Drugs	The Maximum Out-Of-Pocket for pharmacy benefits in 2019 is $2,900 Individual / $5,800 Family. Out of pocket maximum Includes generic and preferred brand name copays and cost shares.			
	Participating Pharmacy / Other Pharmacy	Participating Pharmacy / Other Pharmacy	Participating Pharmacy / Other Pharmacy	Participating Pharmacy / Other Pharmacy
Retail Pharmacy	85% generic and preferred brand 50%, non-preferred brand with a $50 minimum copayment / 85%	85% generic and preferred brand 50%, non-preferred brand with a $50 minimum copayment / 85%	85% generic and preferred brand 50%, non-preferred brand with a $50 minimum copayment / 85%	85% generic and preferred brand 50%, non-preferred brand with a $50 minimum copayment / 85%
Mail Order	$15 copay Generic $50 copay Preferred Brand $100 copay Non Preferred Brand dispensed up to a 90 day supply	$15 copay Generic $50 copay Preferred Brand $100 copay Non Preferred Brand dispensed up to a 90 day supply	$15 copay Generic $50 copay Preferred Brand $100 copay Non Preferred Brand dispensed up to a 90 day supply	$15 copay Generic $50 copay Preferred Brand $100 copay Non Preferred Brand dispensed up to a 90 day supply
Vision	Separate Vision Plan available	Separate Vision Plan available	**Preferred Provider** / **Non-Preferred Provider**	**Preferred Provider** / **Non-Preferred Provider**
Exam			Exam benefit is once every 12 months	Exam benefit is once every 12 months
Eye Exam Child (up to age 19)			100% / 100% up to $150	100% / 100% up to $150
Eye Exam Adult			$25 copay, 100% to $250 maximum / $25 copay; 60% to $250 maximum	$25 copay, 100% to $250 maximum / $25 copay; 60% to $250 maximum
Hardware			*Discount programs are available at certain facilities when you show your Premera ID Card. Visit www.premera.com/sharedadmin and select the "Eye care services and hardware" under Discounts from Premera Blue Cross.*	
Contacts			80% to $150 maximum per calendar year	80% to $150 maximum per calendar year
Lens			80% to $250 maximum, once per calendar year	80% to $250 maximum, once per calendar year
Frames			80% to $200 maximum, once every two calendar years; once per calendar year children up to age 19	80% to $200 maximum, once every two calendar years; once per calendar year children up to age 19