2022 Medical Plans Summary

	A5 Medical Plan Summary	A6 Medical Plan Summary	AV8 Medical Plan Summary	AV9 Medical Plan Summary
Composite Rate	**2022 - $1,376.00**	**2022 - $978.00**	**2022 - $ 994.00**	**2022 - $1,050**
Mixed 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	Yes - Up to 3 months in a twelve month period			
Life Insurance Employee Dependents	 $10,000 $5,000 spouse; $5,000 child 14 days or older, but less than age 26			
Type of Plan	PPO - Preferred Provider *and* Non-Preferred Provider			
Pharmacy Network	MaxorPlus			
Provider PPO Network	Premera Blue Cross www.premera.com or 1-800-810-BLUE(2583)			
Vision Provider Network AV8 and AV9 Plans	VSP Choice www.vsp.com or (800) 877-7195			

This is only a summary of the key coverage provisions of the medical plans effective January 1, 2022 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.

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	A5 Medical Plan Summary		A6 Medical Plan Summary		AV8 Medical Plan Summary		AV9 Medical Plan Summary	
	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 Naturopath, Acupuncture, and Massage Therapist	$20 copay, 90% maximum 24 visits per calendar year	$20 copay, 70%	$25 copay, 80% maximum 24 visits per calendar year	$25 copay, 60%	$25 copay, 80% maximum 24 visits per calendar year	$25 copay, 60%	$25 copay, 100% maximum 24 visits per calendar year	$25 copay, 60%
Therapy Physical, Occupational and Speech	$20 copay, 90% maximum 48 visits per calendar year	$20 copay, 70%	$25 copay, 80% maximum 48 visits per calendar year	$25 copay, 60%	$25 copay, 80% maximum 48 visits per calendar year	$25 copay, 60%	$25 copay, 100% maximum 48 visits per calendar year	$25 copay, 60%
Chemo and Rediation	no visit limits		no visit limits		no visit limits		no visit limits	

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	Preferred Provider	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**
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)	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 price or $500 monthly rental fee	70%	80% Pre-authorization required for DME over $2,000 purchase price or $500 monthly rental fee	60%	80% Pre-authorization required for DME over $2,000 purchase price or $500 monthly rental fee	60%	80% Pre-authorization required for DME over $2,000 purchase price or $500 monthly rental fee	60%
Organ Transplant	90% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	70%	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60%	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60%	80% Benefit available after six month waiting period; special rules and limits apply to Organ Transplants	60%

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THE FOLLOWING BENEFITS ARE NOT SUBJECT TO THE DEDUCTIBLE, DO NOT APPLY TOWARDS THE MEDICAL ANNUAL OUT OF POCKET AND ARE LIMITED TO THE BENEFITS INDICATED.				
Chiropractic	Spinal Exam $20 copay, one per year Spinal X-rays $200 maximum per year Spinal Adjustments $20 copay, up to 24 adjustments per year	Spinal Exam $25 copay, one per year Spinal X-rays $200 maximum per year Spinal Adjustments $25 copay, up to 24 adjustments per year	Spinal Exam $25 copay, one per year Spinal X-rays $200 maximum per year Spinal Adjustments $25 copay, up to 24 adjustments per year	Spinal Exam $25 copay, one per year Spinal X-rays $200 maximum per year Spinal Adjustments $25 copay, up to 24 adjustments per year
Prescription Drugs	The Maximum Out-Of-Pocket for pharmacy benefits in 2022 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				
Generic Preferred Brand Non-Preferred Brand	15% copay 30% copay 50%, $50 minimum copay / Must pay for Rx and submit for reimbursement	15% copay 30% copay 50%, $50 minimum copay / Must pay for Rx and submit for reimbursement	15% copay 30% copay 50%, $50 minimum copay / Must pay for Rx and submit for reimbursement	15% copay 30% copay 50%, $50 minimum copay / Must pay for Rx and submit for reimbursement
Mail Order	Up to a 90-day supply	Up to a 90-day supply	Up to a 90-day supply	Up to a 90-day supply
Generic	15% up to $15 Copay	15% up to $15 Copay	15% up to $15 Copay	15% up to $15 Copay
Preferred Brand	30% up to $50 Copay	30% up to $50 Copay	30% up to $50 Copay	30% up to $50 Copay
Non-Preferred Brand	$100	$100	$100	$100
Vision	Separate Vision Plan available	Separate Vision Plan available	**VSP Provider** / **Non VSP Provider**	**VSP Provider** / **Non VSP Provider**
Wellvision Exam Every calendar year			$0 copay / Up to $101 copay	$0 copay / Up to $101 copay
Frames Every calendar year			$0 copay $200 allowance / Up to $110 copay	$0 copay $200 allowance / Up to $110 copay
Lens Every calendar year				
Single vision, lined bifocal and lined trifocal			$0 copay / Up to $80 copay	$0 copay / Up to $80 copay
Progressive lenses			$55 copay / Up to $62 copay	$55 copay / Up to $62 copay
Contacts *(instead of glasses)*			$300 allowance / Up to $285 copay	$300 allowance / Up to $285 copay
Contact Lens Exam *(fitting and evaluation)*			Up to $60 copay	Up to $60 copay