Medical Plans Summary

This is only a summary of the key coverage provisions of the medical plans effective January 1, 2024 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. Any questions regarding these medical plans, please contact the Trust office at (253) 474-1214.

	A5 Medical Plan Summary	A6 Medical Plan Summary	AV8 Medical Plan Summary	AV9 Medical Plan Summary
Composite Rate	**2024 - $1,410.00**	**2024 - $1,027.00**	**2024 - $1,044.00**	**2024 - $1,103.00**
Mixed Rate	Employee only - $776.00 Emp + Child(ren) - $1,552.00 Emp + Spouse - $1,473.00 Family - $2,328.00			

These medical plans are not managed care plans, do not have a waiting period, no pre-existing condition exclusion and do not require a referral to see a specialist.

Provider PPO Network	Premera Blue Cross www.premera.com or (800) 810-BLUE(2583)
Pharmacy Network	MaxorPlus www.maxorplus.com or (877) 829-9961
Vision Provider Network	VSP Choice www.vsp.com or (800) 877-7195
Coordination of Benefits	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	$10,000
Dependents	$5,000 spouse; $5,000 child 14 days or older, but less than age 26

	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

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	Preferred Provider	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**
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%	$20 copay, 70%	$25 copay, 80%	$25 copay, 60%	$25 copay, 80%	$25 copay, 60%	$25 copay, 100%	$25 copay, 60%
	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%
Physical, Occupational and Speech	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 and Rediation	no visit limits		no visit limits		no visit limits		no visit limits	
Maternity (inc. 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
Durable Medical Equipment (DME)	90%	70%	80%	60%	80%	60%	80%	60%
	Pre-authorization required for DME over $2,000 purchase price or $500 monthly rental fee							
Prosthetic Devices	90%	70%	80%	60%	80%	60%	80%	60%
Hearing Aid	100% limited to $1,000 per aid, every five years							
Organ Transplant	90%	70%	80%	60%	80%	60%	80%	60%
	Benefit available after six month waiting period; special rules and limits apply to Organ Transplants							

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	Preferred Provider	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**	**Preferred Provider**	**Non-Preferred Provider**
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 2023 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	15% copay	Must pay for Rx and submit for reimbursement	15% copay	Must pay for Rx and submit for reimbursement	15% copay	Must pay for Rx and submit for reimbursement	15% copay	Must pay for Rx and submit for reimbursement
Preferred Brand	30% copay		30% copay		30% copay		30% copay	
Non-Preferred Brand	50%, $50 minimum copay		50%, $50 minimum copay		50%, $50 minimum copay		50%, $50 minimum copay	
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	

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Vision	Not Covered Separate Vision Plan available	Not Covered Separate Vision Plan available	**VSP Provider**	**Non VSP Provider**	**VSP Provider**	**Non VSP Provider**
Wellvision Exam Every calendar year			$10 copay	Up to $101 copay	Same as AV8	Same as AV8
Frames Every calendar year			$0 copay $200 allowance	Up to $110 copay	Same as AV8	Same as AV8
Lens Every calendar year Single vision, lined bifocal, lined trifocal and Impact-resistant lenses for dependent children Lenses include Standard progressive, Scratch-resistant coating, UV Protection			$0 copay	Up to $80 copay	Same as AV8	Same as AV8
Lens Enhancements						
Anti-Reflective Coating			$35 copay	Not Covered	Same as AV8	Same as AV8
Premium or Custom progressive lenses			$55 copay	Not Covered	Same as AV8	Same as AV8
Contacts *(instead of glasses)*			$250 allowance	Up to $235 copay	Same as AV8	Same As AV8
Contact Lens Exam *(fitting and evaluation)*			Up to $60 copay	Not Covered	Same as AV8	Same as AV8

Plan AV8 is Plan A6 with Vision Benefits

Plan AV9 is Plan AV8 with office visits covered at 100% after the $25 copay