

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 w/ HSA		Oak Harbor Freight Regence BC/BS Preferred Plan		WaTWT Medical Plan B	Oregon 206 Plan		
Major Features						Plan D - Indemnity		
Monthly Contribution Rates	COBRA Rates		COBRA Rates		\$698.90 – Full Family (\$725.40 for 2008)	\$1,025.66 – Full Family (DDVR)		
	Employee	\$ 422.41	Employee	\$ 484.34	COBRA Rate \$712.90 - Full Family (\$739.90 for 2008)	\$937.32 Full Family (DDV)		
	Spouse	\$ 422.41	Spouse	\$ 484.34		COBRA Rate \$896.16 – (M/D/V/Rx) \$97.08 (M/Rx)		
	Spouse + 1 Child	\$ 718.10	Spouse + 1 Child	\$ 823.37				
	Spouse + Children	\$ 718.10	Spouse + Children	\$ 823.37				
	1 Child	\$ 422.41	1 Child	\$ 484.34				
	Children	\$ 718.10	Children	\$ 823.37				
	Employee + Spouse	\$ 887.07	Employee + Spouse	\$1,017.11				
	Employee, Spouse + 1 Child	\$1,182.75	Employee, Spouse + 1 Child	\$1,356.15				
	Employee, Spouse & Children	\$1,182.75	Employee, Spouse & Children	\$1,356.15				
	Employee + 1 Child	\$ 718.10	Employee + 1 Child	\$ 823.37				
	Employee + Children	\$ 718.10	Employee + Children	\$ 823.37				
	In-Network	Non-Network	In-Network	Non-Network			All Providers	In Network
Office Visit Co-Pay	NA	NA	\$15	NA	\$20		\$10	80%
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**	\$100 per person to \$300 maximum per family		
Co-Insurance	80%		80%	60%				
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****	\$600 Out of Pocket, including Deductible		
Lifetime Maximum	\$1,000,000 per person		\$1,000,000 per person		\$2,000,000 per person	\$1,000,000		
Medical Provider Network	Regence Blue Cross Blue Shield		Regence Blue Cross Blue Shield		Beech Street/First Choice	Providence Preferred & Caremark		
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.	Recommended, but not mandated – No Penalty for non-compliance.		
Emergency Room	80% after deductible		100% after \$75 copay (copay waived if admitted)	60% after deductible	80% after the deductible and \$75 copay per visit (copay waived if admitted)	\$100 Copayment, then 100%		
Hospital Charges	80% after deductible	60% after deductible	80% after deductible	\$250 copay per visit then 60% after deductible	80% after deductible	90%	80%	
Physician Services								
Office Visits	80% after deductible	60% after deductible	100% after \$15 copay per visit Not subject to deductible	60% after deductible	100% after \$20 copay per visit. Not subject to deductible	\$10 copay	80%	
Preventive Care	100% no deductible, unlimited		100% No deductible. \$500/yr. Max	60% after deductible	100% after \$20 copay per visit (includes exam and routine lab and x-ray) Upto \$500 per person per calendar year	\$10 copay to \$250 per yr	NC	

	Oak Harbor Freight Regence BC/BS w/ HSA		Oak Harbor Freight Regence BC/BS Preferred Plan		WaTWT Medical Plan B	Oregon 206 Plan
Surgery and Other Professional Services	80% after the deductible		80% after the deductible		60% after the deductible	90% 80%
Other Plan Benefits						
Alternative Treatment Settings, in lieu of Hospitalization	80% after the deductible				80% after the deductible	Subject to review
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	90% 80%
Hospice Care	Maximum 6 months lifetime		Maximum 6 months lifetime, 80% after deductible		Maximum \$10,000 lifetime	100% 100%
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	90% 80%
Ambulance	80% after the deductible		80% after the deductible		80% after the deductible	80% (Subject to UCR)
Durable Medical Equipment	80% after the deductible		80% after the deductible		80% after the deductible	90% 80%
					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	90% 80%
Inpatient Rehabilitation	80% after the deductible		80% after the deductible	\$250 copay then 60% after the deductible	80% after the deductible	90% 80%
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	\$10 copay up to 60 visits 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	90% With Limitations 80%
					Maximum 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	Not Covered
Organ Transplant	\$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 the outpatient services. Covered after 6 continuous months in plan.	Covered as medically Indicated with a \$8,000 limit in Organ Donor Cost
Spinal Treatment	80% after the deductible		80% after the deductible		100% after \$20 copay per visit, x-rays covered at 80% after deductible	\$15 for Spinal Manipulation, with 26 visits in a six month period.
					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	Not Covered
					Limited to 15 visits per person per calendar year. Acupuncturist must be a PPO provider	
Mental Health - Inpatient	80% after the deductible	60% after the deductible	80% after the deductible	\$250 copay then the 60% after the deductible	100% of authorized network charges or 50% for authorized non-network charges. No deductible	7 Days or \$7,500 – Adult 14 Days or \$8,000 - Child
	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	

	Oak Harbor Freight Regence BC/BS w/ HSA	Oak Harbor Freight Regence BC/BS Preferred Plan		WaTWT Medical Plan B	Oregon 206 Plan			
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 \$2,000 or 33 days			
	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.	\$4,500 Adult \$3,500 Adult \$1,500 Adult	I/P Res O/P	\$5,500 Child \$4,500 Child \$2,000 Child
	\$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 procedures approved by Trust. Special rules.	Not Covered		
					All Providers			
Jaw Treatment (including TMJ and MPD)	\$5,000 every 24 months. \$10,000 lifetime		Office visits 100% after \$15 copay. Hospital and care 80% after deductible	60% after the deductible	80% after the deductible	TMJ \$4,000 Lifetime Maximum		
	\$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 %400 per person every 3 calendar years. Cochlear implants covered under regular benefits. Max waived for children with congenital defects.	Not Covered		
Prescription Drugs								
Retail Network	Caremark Up to 34-day supply or 100 units		Caremark Up to 34-day supply or 100 units		NBN/Rx Up to 34-day supply		In-Network (Fred Meyer, QFC and Safeway):	
					Recommended Pharmacy	Regular Pharmacy		
Generic	80% after the deductible		100% after \$10 copay		100% after copay equal to larger of \$15 or 30%	100% after copay equal to larger of \$10 or 40%	10% copay with a \$5 minimum	
Formulary	80% after the 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%	10% copay with a \$10 minimum	
Non-Formulary	80% after the 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%	20% copay with a \$20 minimum	
Retail Non-Network Pharmacy	Not covered		Not covered		Not covered except in medical emergency		15%/\$10 Generic; 15%/\$15 Pref. Br.; 25%/\$25 NonPreferred Br	
Mail Order	Not Available		Caremark Mail Services. Up to a 90 day supply		Union Center Pharmacy. Up to 100 day supply		90 Day Supply at two copayments for maintenance meds. / 30-Day supply at on copay for non-maintenance meds.	
Generic	N/A		100% after \$20 copay		100% after \$10 copay		100% after \$10 copay	
Preferred Brand	N/A		100% after \$50 copay		100% after \$35 copay		100% after \$20 copay	
Non-Preferred Brand	N/A		100% after \$80 copay		100% after \$35 copay		100% after \$40 copay	
Contraceptives	Covered		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; \$1,500 lifetime		Covered	
Miscellaneous Other								

	Oak Harbor Freight Regence BC/BS w/ HSA	Oak Harbor Freight Regence BC/BS Preferred Plan	WaTWT Medical Plan B	Oregon 206 Plan
Benefits				
Coordination of Benefits (COB)	Standard COB	Standard COB	Standard COB	Standard COB
Pre-existing Conditions	3 month waiting period less any creditable coverage	3 month waiting period less any creditable coverage	No waiting period	Not Applicable
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	Up to age 19, and from 19 through 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	Not included
Disability Extension of Coverage	Information not found*	Information not found*	3 months included. Additional 9 available	Cal.Yr. of disability, plus an additional 12 months, with limitations
Life/AD&D Insurance	\$15,000 per employee	\$15,000 per employee	Not included – Plan A, B or available	\$4,100 per employee
Time Loss Benefits	Information not found	Information not found	Not included – Plan A, B C or D available. 1 st day coverage for accident, 1 week wait for illness, 26 weeks equivalent maximum.	26 weeks of TL, 12 month waiver of premium. First day accident, 8 th day illness.
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.	Not Covered

* Excludes penalties and intangible 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 co-pays.

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
Time Loss – 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