WASHINGTON TEAMSTERS WELFARE TRUST

Medical Plan Highlights – 2026

Medical Plan Z

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. For more information visit the Trust's website at **www.wateamsters.com**.

	Medical Plan Z	
Monthly Contribution Rate (Full family)	**$1,530.40**	
Major Features		
	PPO	**Non-PPO**
Office Visit Co-payments (Per visit)	**$25**	
Annual Deductible (Does not apply to office visits subject to copays, prescription drugs, or obesity programs)	If Wellness Program incentives are met: $400 per person; $1,200 per family If Wellness Program incentives are NOT met: $600 per person; $1,800 per family New Hires: $500 per person; $1,500 per family	
Coinsurance (Applies to most benefits)	**80%**	**50%**
Annual Co-insurance Out-of-Pocket Maximum* (Includes co-insurance only)	**$5,000** per person; **$10,000** per family	
Annual Out-of-Pocket Maximum**	**$5,000** per person; **$10,000** per family	
Hospital/Physician PPO Network	Premera – BlueCard PPO	
Coordination of Benefits (COB)	Standard COB	
Hospital / Emergency Room Benefits		
Hospital Inpatient Pre-certification	Required; $200 penalty if not pre-certified.	
Hospital (Facility charges)	80% after deductible	50% after deductible
Emergency Room Care	$75 copay per visit (waived if admitted), then	
	80% after deductible	80% after deductible
Physician Services		
Office Visits	100% after $25 copay per visit	
Preventive Care	100%	50% after $25 copay per visit
Other Professional Services	80% after deductible	50% after deductible
Other Plan Benefits		
Diagnostic X-Ray/Lab	80% after deductible	50% after deductible
Treatment in Lieu of Hospitalization	80% after deductible	50% after deductible
Home Health Care	Maximum 130 visits per calendar year	
Hospice Care	Maximum 60 visits lifetime	
Skilled Nursing Facility	Maximums of 180 days per condition	
Durable Medical Equipment (Pre-authorization required for equipment over $2,000 in purchase price or $500 per month in rental cost)	80% after deductible	50% after deductible
Inpatient Rehabilitation	80% after deductible	50% after deductible
Organ Transplants (Special rules and limits; covered after six-month waiting period)	80% after deductible	50% after deductible
Outpatient Physical/Occupational Therapy (Maximum 24 visits of each therapy per per-son/calendar year; 48 visits of each therapy following accident, surgery, or stroke)	100% after $25 copay per visit	
Speech Therapy (Maximum 60 visits per lifetime[1])	100% after $25 copay per visit	

	Medical Plan Z		
	PPO		**Non-PPO**
Massage Therapy (If prescribed by physician for diagnosed injury or illness; maximum 20 visits per person per calendar year)	100% after $25 copay per visit		
Spinal Treatment (Maximum 20 visits per person per calendar year)	100% after $25 copay per visit		
Acupuncture (Maximum 20 visits per person per calendar year)	100% after $25 copay per visit		Not covered
Naturopathic (supplies, etc. are not covered)	100% after $25 copay per visit		Not covered
Hearing Aids (Up to $1,000 per ear every 36 months; maximum waived for child with congenital defect; regular benefits for cochlear implants)	80% after deductible		50% after deductible
Jaw Treatment	80% after deductible		50% after deductible
Mental Health or Substance Abuse *Inpatient (see prior auth req. above)*	80% after deductible		50% after deductible
Outpatient	$10 copay per session		$10 copay per session
Prescriptions –MedImpact Rx Network			
Retail Network Pharmacy	Up to 34-day supply		
	Recommended Pharmacy	Regular Network	
Generic	10% copay	15% copay	Not covered except for a medical emergency
Formulary Brand	30% copay	35% copay	Not covered except for a medical emergency
Non-Formulary Brand	40% copy	45% copay	Not covered except for a medical emergency
Mail Order Pharmacy	Up to a 100-day supply		
Generic	Copay is 10% up to maximum of $15		Not covered except for a medical emergency
Formulary Brand	Copay is 30% up to maximum of $90		Not covered except for a medical emergency
Non-Formulary Brand	Copay is 40% up to maximum of $130		Not covered except for a medical emergency
Annual Prescription Out-of-Pocket Maximum (Includes in-network prescription copays only; excludes out-of-network expenses)	$5,600 per person; $11,200 per family per calendar year		No maximum
Contraceptives	Covered		
Managed Program (Utilization management and intervention, clinical edits, and step therapy for certain therapeutic categories)	Yes		
Other Benefits			
Nurse Advice Line	Available 24/7		
Assistance (EAP) Program	Up to 3 face-to-face counseling sessions per incident per person per calendar year for short-term professional counseling; unlimited telephone counseling		
Virtual Office Visits	Teladoc at $0 copay, otherwise covered as office visit with $25 copay		100% after $25 copay per visit
Wellness Programs	Health coaching for certain health risks paid at 100%. $50 incentive if participating in health coaching for identified health risks. No copays on medication for diabetes, asthma, or coronary artery disease to participate in chronic condition management program for these conditions. Tobacco cessation program includes coaching and nicotine replacement therapies (patch and gum) paid at 100%. Must be in the tobacco cessation coaching program for coverage.		
Accolade Personal Health Support - Get personalized, confidential help navigating your health and benefits.	Accolade will help you: • Understand your benefits • Learn more about your care options • Resolve claim issues • Schedule doctor appointments • Find an in-network provider • Connect with Virtual Care • Obtain a Second Opinion • Join Virta (if you qualify) for: - Diabetes Reversal Treatment - Sustainable Weight Loss		
Surgical Weight-Loss/Bariatric Surgery (Special rules.)	Requires prior authorization and use of a Premera Center of Excellence (COE). 80% coverage for approved services (straight 80% coverage by the Trust and patient is responsible for 20% even if the out-of-pocket maximum for other services is met)		Not covered

Ancillary Benefits	
Disability Waivers (Extension of coverage)	3 months included. Additional 9 months may be added.
Life/AD&D Insurance	Not included –A, B, or C plan may be added.
Time Loss Benefits	Not included –A, B, C or D plan may be added.
Domestic Partners	Not included. May be added.

* Applies to out-of-pocket expenses for co-insurance only. Once an individual's out-of-pocket expenses for co-insurance have reached the out-of-pocket maximum during a calendar year, the plan pays expenses that are subject to co-insurance at 100% for the rest of that calendar year. Out-of-pocket expenses for weight-loss program, annual deductible, co-payments, prescription drugs, non-covered expenses, charges over usual and customary charges, and penalties for not pre-certifying hospitalizations do not apply to the out-of-pocket maximum.

** Applies to out-of-pocket expenses for co-insurance, copays, and deductible. If this maximum is met then no further coinsurance or copays have to be paid for the remainder of the calendar year. This does not include prescription drug copays, which have a separate out-of-pocket maximum; also does not include weight management benefits.

[1] W*hen speech therapy services are provided to treat developmental conditions identified as mental disorders in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), the Plan will not impose age, visit or dollar limits on medically necessary therapies.*

Non-PPO benefits may be subject to Usual Customary and Reasonable (UCR) limits.

Ancillary Benefit Add-ons		**Monthly Rate**
Employee Life, AD&D and Dependent Life		
Plan A	$30,000 employee/$3,000 dependent	$ 8.60
Plan B	$15,000 employee/$1,500 dependent	$ 4.40
Plan C	$ 5,000 employee/$ 500 dependent	$ 1.60
Additional 9 Month Disability Waiver		
9 Month Disability Waiver		$ 11.40
Time Loss – Employee Only		
Time Loss Plan E	Weekly benefit: $500	$ 30.00
Time Loss Plan A	Weekly benefit: $400	$ 18.00
Time Loss Plan B	Weekly benefit: $300	$ 11.00
Time Loss Plan C	Weekly benefit: $200	$ 6.00
Time Loss Plan D	Weekly benefit: $100	$ 3.00
Domestic Partners		
Same and Opposite Sex		$ 18.00