

WASHINGTON TEAMSTERS WELFARE TRUST

JC-28XL Medical Benefits Summary

| Major Plan Features | If You Use a PPO Provider | If You Use a Non-PPO Provider |
|--|--|---|
| Deductibles | | |
| ▪ Emergency Room | No deductible | \$25 per visit |
| ▪ Hospitalization | No deductible | No deductible |
| ▪ Physician Services | No deductible | No deductible |
| ▪ Durable Medical Equipment and Supplies | \$100 per family per calendar year 3-month carryover applies | |
| Out-of-Pocket Maximum | \$500 per family per calendar year ¹⁾ | |
| Lifetime Maximum | \$2,000,000 per person | |
| PPO Network | First Choice Health Network | |
| Hospital | Plan pays 100% of PPO allowed amount | Plan pays 100% of first \$2,000 of charges, then 90% of usual, customary and reasonable (UCR) charges |
| ▪ Pre-certification/Utilization Review | Benefit payment is reduced by 10% for days not certified by Qualis Health as medically necessary. Call Qualis Health at 877-372-7861 to pre-certify. | |
| Physician Services | | |
| ▪ Inpatient, Outpatient, Surgery | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| Preventive Care | | |
| ▪ Physical exams, Immunizations and Well-Baby Care | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| Diagnostic Lab and X-Ray | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| Spinal Treatment | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| | Maximum of \$100 per calendar year for diagnostic tests and X-rays; maximum of 15 treatments per calendar year combined PPO and non-PPO | |
| Acupuncture Treatment | Plan pays 90% of PPO allowed amount to \$500 per calendar year | Not Covered |
| Alternative Treatment Settings | Instead of hospitalization, Plan pays 100% of PPO allowed amount | Instead of hospitalization, Plan pays 100% of first \$2,000 of charges, then 90% of usual, customary and reasonable (UCR) charges |
| ▪ Skilled Nursing Facility | Up to \$110 per day and 180 days per same or related condition | |
| ▪ Hospice | Up to \$10,000 per lifetime | |
| ▪ Home Health Care | Up to 130 visits per calendar year | |

This plan summary is not intended to be an all-inclusive description of Plan benefits and does not list all specific Plan provisions, limitations, or exclusions. This summary should not be used in lieu of a Plan booklet. Please refer to your Plan booklet for a complete description of Plan benefits. (12/10/2008)

| Other Plan Benefits (continued) | | |
|--|---|------------------------------|
| Hearing Aids | Plan pays 90% of UCR allowed amount; maximum of \$1,000 per ear per person every 36 months (maximum waived for children with a congenital defect) | |
| Organ Transplants | Special rules and limits apply. \$200,000 per transplant maximum per confinement | |
| Jaw Conditions <ul style="list-style-type: none"> ▪ All jaw treatment that is not the result of accidental injury, including Temporomandibular Joint (TMJ) Disorder and Myofascial Pain Disorder (MPD) | Plan pays 80% of PPO allowed | Plan pays 80% of UCR charges |
| | Lifetime maximum of \$6,000 per person. | |
| Massage Therapist Treatment | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| | Up to 12 visits per calendar year per person ²⁾ | |
| Maternity Program | Plan pays 90% of PPO allowed amount | Plan pays 90% of UCR charges |
| | \$200 copay if mother does not participate and successfully complete the Taking Care of Us Maternity Program. | |

The coinsurance percentages listed in this summary refer to:

- Percentage of UCR (usual, customary, and reasonable) charges for a non-PPO (non-network) provider
- Percentage of PPO (network) providers' discounted charges for a PPO (network) provider

¹⁾ Once an individual reaches the Medical Plan out-of-pocket maximum for coinsurance during a calendar year, the Plan pays most eligible expenses at 100% for the rest of that calendar year. Costs in excess of the \$200,000 organ transplant maximum, costs for mental health treatment, chemical dependency treatment, prescription drug expenses, non-covered expenses, charges over UCR amounts, and penalties for not pre-certifying hospitalizations do not apply to the out-of-pocket maximum for coinsurance.

²⁾ Benefit limits on number of visits or days apply whether or not the visits or days are subject to the deductible. Requires a prescription from your prescribing provider.

Send Medical claims to:

Washington Teamsters Welfare Trust
 PO Box 21003
 Seattle, WA 98111

This plan summary is not intended to be an all-inclusive description of Plan benefits and does not list all specific Plan provisions, limitations, or exclusions. This summary should not be used in lieu of a Plan booklet. Please refer to your Plan booklet for a complete description of Plan benefits. (12/10/2008)

Prescription Drug Program

| Prescription Drug Program | | |
|--|---|---|
| Retail Pharmacy (up to 34-day supply) | Generic Drugs | Brand-Name Drugs |
| <i>Recommended</i> Network Pharmacy | 100% (of discounted price) | 90% (of discounted price) |
| <i>Regular</i> Network Pharmacy | 90% (of discounted price) | 80% (of discounted price) |
| Retail Non-Network Pharmacy (covered for medical emergencies only) | 100% after \$9 handling fee <i>plus</i> your normal copay or cost share | |
| Mail Order Pharmacy (up to a 100-day supply) | 100% (no copay required) | 100% after a \$20 copay per prescription* |
| Contraceptives | Covered, retail or mail order | Covered, retail or mail order |

*You pay \$20 copay per prescription if you receive a brand name drug when a generic substitution is available. The generic name of a drug is simply its chemical name. Generic drugs meet strict requirements under the FDA and are as safe, efficient and effective as brand-name drugs, but are considerably less expensive. Unless otherwise specified by your doctor, your prescriptions will be filled with generic drugs. Certain new and/or high-cost prescriptions may be limited to a trial dose (instead of the 100-day supply) on the first and possibly second order of a new prescription to determine patient tolerance and drug effectiveness.

Weight Loss Programs

| Weight Loss Programs – Pre-authorization required | |
|---|---|
| Non-Surgical Program, Surgery, and Pre- and Post-Surgery Programs | 80%. Participant pays 20% plus monthly cost of web-based programs where applicable. Contact Sound Health Solutions at 425-747-6000 for more information. |

This plan summary is not intended to be an all-inclusive description of Plan benefits and does not list all specific Plan provisions, limitations, or exclusions. This summary should not be used in lieu of a Plan booklet. Please refer to your Plan booklet for a complete description of Plan benefits. (12/10/2008)

Mental Health and Chemical Dependency Benefits Program

| Benefit | Network Provider/Facility | Non-Network Provider/Facility |
|--|---|--|
| Assistance Program | | |
| Assessment Visits | Call 800-256-9888 24 hours a day, 7 days a week. Program pays 100% up to 3 outpatient assessment visits per person per incident per calendar year. Must be authorized by MHN. | None |
| Mental Health Treatment Program | | |
| Outpatient | Program pays 100% after applicable copay if you preauthorize with MHN. Program pays 50% after applicable copay if you do not preauthorize treatment with MHN. | Program pays 50% of UCR. MHN preauthorization is not required. |
| | Individual Sessions copay: 1-20 sessions– \$10 copay 21-50 sessions– \$15 copay | Group Sessions copay: 1-20 sessions– \$5 copay 21-50 sessions– \$7.50 copay |
| | Up to 50 authorized individual/group sessions per person per calendar year, combined network and non-network. | |
| Inpatient/Alternate Care and Residential/Partial Treatment | Program pays 100% if you preauthorize with MHN. Program pays 50% if you do not preauthorize treatment with MHN. | Program pays 50% of UCR if you preauthorize with MHN. No benefits are available if you do not preauthorize treatment with MHN. |
| | Up to 45 days of authorized residential/inpatient/alternate/partial care treatment per person per calendar year combined network and non-network. 90 days lifetime maximum per eligible participant. 2 days of residential and/or partial treatment equal 1 day of inpatient treatment. | |
| Chemical Dependency Treatment Program | | |
| Inpatient/Outpatient | Program pays 100% if you preauthorize with MHN. Program pays 50% if you do not preauthorize treatment with MHN. Includes SAP services for active employees who fail a DOT alcohol or drug test. | Program pays 50% of UCR if you preauthorize with MHN. No benefits are available if you do not preauthorize treatment with MHN. |
| | Up to \$10,000 per episode* (including detoxification), per person. Lifetime maximum of 2 episodes of chemical dependency treatment, including detoxification, per eligible participant. MHN preauthorization is required. | |

**An episode is defined as any continuous course of treatment that focuses on a particular occurrence of a chemical dependency problem. An episode may involve various levels of care and/or treatment by one or more providers or facilities as a part of a continuum of medically necessary and clinically appropriate treatment of the presenting problem. Treatment of a relapse of the treated condition within 60 days of a participant's completion of all MHN recommended levels of care is considered to be the same episode.*

Send Mental Health and Chemical Dependency claims to:

MHN
PO Box 14621
Lexington, KY 40512

This plan summary is not intended to be an all-inclusive description of Plan benefits and does not list all specific Plan provisions, limitations, or exclusions. This summary should not be used in lieu of a Plan booklet. Please refer to your Plan booklet for a complete description of Plan benefits. (12/10/2008)