



WASHINGTON TEAMSTERS WELFARE TRUST

Medical Plan Comparison – 2026

Medical Plans A, B & 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 A		Medical Plan B		Medical Plan Z	
<i>Major Features</i>	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Office Visit Co-payments (per visit)	\$20		\$25		\$25	
Annual Deductible (Does not apply to office visits subject to copays, prescription drugs, or obesity programs)	If Wellness Program incentives are met: \$100 per person; \$300 per family If Wellness Program incentives are NOT met: \$300 per person; \$900 per family New Hires \$200 per person; \$600 per family		If Wellness Program incentives are met: \$200 per person; \$600 per family If Wellness Program incentives are NOT met: \$400 per person; \$1,200 per family New Hires \$300 per person; \$900 per family		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)	90%	70%	80%	60%	80%	50%
Annual Co-insurance Maximum*	\$1,500 per person; \$3,000 per family		\$2,500 per person; \$5,000 per family		\$5,000 per person; \$10,000 per family	
Annual Out-of-Pocket Maximum (Excludes prescriptions and non-covered charges or services)	\$5,000 per person; \$10,000 per family	NA	Same as A		Same as A	
Hospital/Physician PPO Network	Premera – Blue Card PPO		Same as A		Same as A	
Coordination of Benefits (COB)	Standard COB		Same as A		Same as A	
<i>Hospital / Emergency Room Benefits</i>						
Hospital Inpatient Pre-certification	Required; \$200 penalty if not pre-certified.		Same as A		Same as A	
Hospital (facility charges)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Emergency Room Care	\$75 copay per visit (waived if admitted), then		\$75 copay per visit (waived if admitted), then		\$75 copay per visit (waived if admitted), then	
	90% after deductible	90% after deductible	80% after deductible	80% after deductible	80% after deductible	80% after deductible
<i>Physician Services</i>						
Office Visits	100% after \$20 copay per visit		100% after \$25 copay per visit		100% after \$25 copay per visit	
Preventive Care	100%	70% after \$20 copay per visit	100%	60% after \$25 copay per visit	100%	50% after \$25 copay per visit
Other Professional Services	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
<i>Other Plan Benefits</i>						
Diagnostic X-Ray/Lab	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Durable Medical Equipment	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Organ Transplants (Special rules and limits; covered after six month waiting period)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible

	Medical Plan A		Medical Plan B		Medical Plan Z	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Treatment in Lieu of Hospitalization	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
<i>Home Health Care</i>	Maximum 130 visits per calendar year		Same limits as A		Same limits as A	
<i>Hospice Care</i>	Maximum 60 visits lifetime		Same limits as A		Same limits as A	
<i>Skilled Nursing Facility</i>	Maximums of 180 days per condition		Same limits as A		Same limits as A	
Inpatient Rehabilitation	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Outpatient Physical/Occupational Rehabilitative or Habilitative Therapy (Maximum 24 visits of each therapy per person/calendar year; 48 visits of each following accident, surgery, or stroke)	100% after \$20 copay per visit		100% after \$25 copay per visit		100% after \$25 copay per visit	
Speech Therapy (Maximum 60 visits per lifetime ¹)	100% after \$20 copay per visit		100% after \$25 copay per visit		100% after \$25 copay per visit	
Massage Therapy (For diagnosed injury/illness; maximum 20 visits per person per calendar year)	100% after \$20 copay per visit		100% after \$25 copay per visit		100% after \$25 copay per visit	
Spinal Treatment (Maximum 20 visits per person per calendar year)	100% after \$20 copay per visit		100% after \$25 copay per visit		100% after \$25 copay per visit	
Acupuncture (Maximum 20 visits per person per calendar year)	100% after \$20 copay per visit	Not covered	100% after \$25 copay per visit	Not covered	100% after \$25 copay per visit	Not covered
Naturopathic (supplies, etc. not covered)	100% after \$20 copay per visit	Not covered	100% after \$25 copay per visit	Not covered	100% after \$25 copay per visit	Not covered
Hearing Aids (Up to \$1,000 per ear every 36 months; maximum waived for cochlear implants; and child with congenital defect)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Jaw Treatment (Includes TMJ and MPD)	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
Mental Health or Substance Abuse						
<i>Inpatient (see prior auth req. above)</i>	90% after deductible	70% after deductible	80% after deductible	60% after deductible	80% after deductible	50% after deductible
<i>Outpatient</i>	100% after \$10 copay per visit/session	100% after \$10 copay per visit/session	Same as A	Same as A	Same as A	Same as A
Other Benefits						
Accolade Personal Health Support	<p>Accolade participant advocacy - Get personalized, confidential help navigating your health and benefits. Accolade will help you:</p> <ul style="list-style-type: none"> • Understand your medical, dental and vision benefits; Learn more about your care options; • Resolve claim issues and billing questions; • Find an in-network provider; Schedule doctor appointments; • Connect with virtual care; obtain a Second Opinion; • Join Virta for <i>Diabetes Reversal Treatment</i> or <i>Sustainable Weight Loss</i> 					
Wellness Programs	Health Assessments with a lower annual deductible as an incentive. Health coaching for certain health risks paid at 100% and with \$50 incentive to participate. Free 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 the Rx coverage.					
Nurse Advice Line	Available 24/7		Same as A		Same as A	

	Medical Plan A		Medical Plan B		Medical Plan Z		
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
Virtual Office Visits	Teladoc at \$0 copay, otherwise covered as office visit with \$20 copay	100% after \$20 copay per visit	Teladoc at \$0 copay, otherwise covered as office visit with \$25 copay	100% after \$25 copay per visit	Teladoc at \$0 copay, otherwise covered as office visit with \$25 copay	100% after \$25 copay per visit	
Assistance (EAP) Program	Up to 3 in-person counseling sessions per incident per person per calendar year for short-term professional counseling; unlimited telephone counseling.		Same as A		Same as A		
Surgical Weight-Loss/Bariatric Surgery (Special rules)	Requires prior authorization and use of a Premera Center of Excellence (COE). (If approved 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	Same as A		Same as A		
Prescriptions – MedImpact Rx Network							
Annual Out-of-Pocket Maximum	\$5,600 per individual; \$11,200 per family		Same as A		Same as A		
Retail Network Pharmacy	Up to 34-day supply		Same as A		Same as A		
	Recommended Pharmacy	Regular Network	Same as A		Same as A		
	Generic	10% copay	15% copay	Same as A		Same as A	
	Formulary Brand	30% copay	35% copay	Same as A		Same as A	
	Non-Formulary Brand	40% copay	45% copay	Same as A		Same as A	
Mail Order Pharmacy	Up to a 100-day supply		Same as A		Same as A		
	Generic	Copay is lesser of 10% and \$15		Same as A		Same as A	
	Formulary Brand	Copay is lesser of 30% and \$90		Same as A		Same as A	
	Non-Formulary Brand	Copay is lesser of 40% and \$130		Same as A		Same as A	
Ancillary Benefits							
Disability Waivers (coverage extension)	3 months included. 9 months may be added.		Same as A		Same as A		
Life/AD&D Insurance	Not included –A, B, or C plan may be added.		Same as A		Same as A		
Time Loss Benefits	Not included –A, B, C, D, E plan may be added.		Same as A		Same as A		
Domestic Partners	Not included. May be added.		Same as A		Same as A		

* Applies to out-of-pocket expenses for co-insurance only. Once an individual's out-of-pocket expenses for co-insurance have reached the 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, and penalties for not pre-certifying hospitalizations do not apply.

¹ When 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
<i>Employee Life, AD&D and Dependent Life</i>		
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
<i>Additional 9 Month Disability Waiver</i>		
9 Month Disability Waiver		\$ 11.40
<i>Time Loss – Employee Only</i>		
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
<i>Domestic Partners</i>		
Same and Opposite Sex		\$ 18.00



WASHINGTON TEAMSTERS WELFARE TRUST

Dental Plan Comparison – 2026

Dental Plan A, B, and C



Please note, the plan features a network of dentists who offer discounts not available outside the network. You can choose to use either in-network or out-of-network dentists, but you'll save money – for you and the Trust – when you use Delta Dental of Washington member dentists. **For questions about your dental benefits or dental claims or to find a Delta Dental member dentist near you:**

- Call Delta Dental toll-free at 800-554-1907, or Delta Dental also has a website at www.deltadentalwa.com/group/teamsters where you can access certain information.

Plan Features	Dental Plan A*	Dental Plan B**	Dental Plan C**
<i>Benefit Maximums</i>			
Calendar Year Maximum Benefit (per person; limit does not apply to essential pediatric oral care for children under age 19)	\$2,675	\$2,675	\$2,675
Orthodontia Benefit (for dependent children under age 26 only)	70% of eligible expenses	70% of eligible expenses	70% of eligible expenses
Orthodontia Lifetime Maximum (per child)	\$2,675	\$2,675	\$2,675
<i>Class 1 – Diagnostic and Preventive</i>			
Periodic Oral Exam	100%	\$ 33.00	\$ 21.00
Bitewing X-rays – two films	100%	\$ 26.00	\$ 17.00
Adult Prophylaxis (teeth cleaning)	100%	\$ 65.00	\$ 46.00
Child Prophylaxis (teeth cleaning)	100%	\$ 45.00	\$ 32.00
Topical Application of Fluoride (excluding cleaning) – child	100%	\$ 25.00	\$ 18.00
Sealants for Children – per tooth	100%	\$ 28.00	\$ 21.00
<i>Class 2 – General and Minor Restorative</i>			
Periodontal Scaling and Root Planing - per quadrant	90%	\$182.00	\$ 77.00
Amalgam Restoration (one surface)	90%	\$ 83.00	\$ 42.00
Root Canal Therapy – molar	90%	\$732.00	\$395.00
Simple Extraction Single	90%	\$ 88.00	\$ 47.00
Surgical Extraction Erupted Tooth	90%	\$179.00	\$101.00
Surgical Extraction Impacted Teeth-Completely Bony	90%	\$350.00	\$188.00
<i>Class 3 – Prosthetic and Major Restorative</i>			
Porcelain Fused to High Noble Metal	75%	\$409.00	\$254.00
Porcelain Fused to Noble Metal	75%	\$390.00	\$251.00

* Plan A covers percentage indicated of Delta Dental’s negotiated fees for Delta Dental dentists; if services are provided by a non-Delta Dental provider, plan covers percentage indicated of Delta Dental’s allowed amount. For a non-Delta Dental provider, the plan participant is responsible for any difference between the allowed amount and the amount charged. General anesthesia is covered when medically necessary for children through age 6 or a physically or developmentally disabled person when in conjunction with any covered dental procedure.

** Plans B & C cover up to the listed schedule (dollar) amount.

^ Domestic Partners (add \$2.20 if bargained)

Please Note: This summary is provided to assist participants in understanding the dental plans. It is not intended to be an all-inclusive description of Plan benefits and does not list all covered procedures, 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 provided here is accurate, if there are any discrepancies between this summary and the official Plan documents and booklets, the official Plan documents and booklets govern.



WASHINGTON TEAMSTERS WELFARE TRUST

Benefit Highlights

WATWT Vision Plan EXT



The following data is for illustrative purposes only. It is **NOT** intended to be construed as an all inclusive description of the Plan benefits or any limitations/exclusions that may apply. It is not to be used for general distribution purposes or in lieu of a Plan booklet. Every reasonable effort has been made to insure that the following information is accurate as of the date of issue; however, in all cases the applicable Plan booklet (inclusive of all revisions or modifications made subsequent to the latest printed editions) shall govern the eligibility for the benefits payable under all Washington Teamsters Welfare Trust programs. The Board of Trustees retains the right of final determination in questions of interpretation.

For a list of providers visit www.nwadmin.com, Resources, NBN Vision Provider Locator tool.

WA Teamsters Vision Plan		
SCHEDULE OF BENEFITS	NBN Panel Provider	Non-Panel Provider
Annual Deductible	None	None
Examination	Paid in Full	\$35.00
	<i>An exam is provided once every 365 days*</i>	
Lenses (per pair)		
• Single Vision	Paid in Full**	\$30.00
• Bifocal	Paid in Full**	\$40.00
• Trifocal	Paid in Full**	\$45.00
• Lenticular	Paid in Full**	\$90.00
	<i>Lenses are provided once every 365 days.*</i>	
Frames	Paid in Full for allowed frames***	\$30.00
	<i>Frames are provided once every 730 days*</i>	
Subnormal Contact Lenses	Paid in Full	\$200.00
	<i>Subnormal contacts provided once every 730 days.*</i>	
Elective Contact Lenses	\$150.00****	\$90.00
	<i>Contacts are provided in lieu of glasses once every 365 days.*</i>	

* These time frames are strictly enforced (i.e., to the day).

** **Paid in full means the cost of covered lenses and covered extras are paid in full.** Extras covered include solid color coating and tinting (e.g sun tints), gradient tints, mirror coating, UV filters, polarized and laminated lenses, glass light-sensitive lenses (light and dark shades, e.g. PhotoSun), plastic light sensitive lenses (e.g. Transitions) standard grades, progressives lenses (no-line bifocals) standard grades, polycarbonate lenses, special lens edge treatments (e.g. drilling, notching, grooving, beveling, or polishing or coating edges), anti-reflective coating + hardening (standard grades), scratch coating, oversize lenses, prism segments, slab off, double segments. Additional care, services and/or materials not covered by the plan may be arranged between patient and vision care provider at patient's expense.

*** Paid in full means for the frames selection covered by the Plan, not all frames. Check with provider.

**** Dollar limit does not apply to an individual under age 19; however, there is a limit of a one-year supply.

^ Domestic Partner Coverage Add \$.20