A6 Medical Plan Summary

Effective 1/1/2026

This is only a summary of the key coverage provisions of the Medical Plan and is not intended to be used for general distribution purposes or in lieu of a Plan Booklet. If there are any discrepancies between this summary and the plan booklet, the plan booklet will govern. If you have questions regarding the medical plan benefits, please contact the Trust office at (253) 474-1214.

Monthly Contribution	$1,090.00
Managed Care Plan	No
Pre-Existing Condition Exclusion	No
Waiting Period	No
Precertification	Required for inpatient admissions, surgeries and select outpatient services
Referral	Referrals are not required
Coordination of Benefits	Yes
Subrogation	Yes
Waiver of Premium	Yes - Up to 3 months in a twelve month period
Annual Plan Maximum	No
COBRA	Yes
Type of Plan	PPO - Preferred Provider *and* Non-Preferred Provider
Provider Network	Premera Blue Cross www.Premera.com or (800) 810-BLUE
Retail Pharmacy Network	VyltOne www.vyltone.com or (877) 829-9961 (previously MaxorPlus)
Life Insurance	Employee $10,000 Spouse $5,000 Child $5,000 (14 days or older, but less than age 26)

These two benefits are not subject to the deductible, do not apply towards the medical annual out of pocket, are subject to the office visit copayment and are limited to the benefits indicated.

Prescription Drugs	**Participating Pharmacy**	**Other Pharmacy**
Retail Pharmacy	Up to a 30 day supply	Up to a 30 day supply
Generic	15% copay	15% copay
Formulary Brand	30% copay	30% copay
Non-Formulary Brand	50% copay, minimum $50	50% copay, minimum $50
Mail Order	Up to a 90 day supply	Not applicable
Generic	15% up to $15 copay	
Formulary Brand	30% up to $50 copay	
Non-Formulary Brand	$100 copay	
Pharmacy Annual Out-Of-Pocket (OOP)	$2,900 Individual / $5,800 Family Once the OOP maximum is met the benefits increase to 100% for the remainder of the year	No annual maximum
Chiropractic	100% after $25 copay; up to 24 adjustments per year 100% after $25 copay on 1 exam per year 100% up to $200 on x-rays per year	

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	Preferred Provider (PPO)	**Non-Preferred Provider (Non-PPO)**
Annual Deductible		
Individual	**$300**	
Family	**$900**	
Office Visit copayment	**$25**	
Individual Cost Share	**20%,** Up to the Annual OOP	**40%**
Annual Out-Of-Pocket (OOP)	$5,000 Individual $10,000 Family Includes PPO deductible, copayments and cost share only. Once the annual OOP maximum is met benefits increase to 100% for the remainder of the year.	No annual maximum
Physician Services		
Office Visit	80% after $25 copay	60% after $25 copay
Other physician services	80%	60%
Preventive Care	100%, no cost share	60% after $25 copay not subject to deductible
Alternative Care	80% after $25 copay	60% after $25 copay
Acupuncture, Naturopath and Massage Therapy	Maximum of 24 visits per year	
Therapy	80% after $25 copay	60% after $25 copay
physical, occupational and speech	Maximum of 48 visits per year	
Maternity (includes Midwives)	80%	60%
Diagnostic; X-ray and Lab	80%	60%
Ambulance	80%	80%
Hospital		
Inpatient and Outpatient	80%	60%
Emergency Room	80% after $150 copay	80% after $150 copay
Home Health Care	80%, 120 visits per year	60%, 120 visits per year
Hospice	80%, 120 days maximum	60%, 120 days maximum
Skilled Nursing Facility	80%, 120 days per condition	60%, 120 days per condition
Durable Medical Equipment (DME)	80%	60%
Pre-authorization required for DME over $2,000 purchase or $500 per month rental		
Prosthetic Devices	80%	60%
Hearing Aid	100% up to $3,000 per aid per ear, every three years	
Organ Transplant	80%	60%
Benefit available after six month waiting period; special rules and limits apply to Organ Transplants.		