

WEA Select Health Plans

October 1, 2010

EasyChoice Plan

Benefits that have changed are highlighted in gray Ded + Coin = Deductible + Coinsurance — Applies to all plans as shown —
 IN = In-network OUT = Out-of-network PCY = Per Calendar Year OT = Occupational therapy PT = Physical therapy

Provider Network	EasyChoice A Heritage		EasyChoice B Heritage		EasyChoice C Foundation		
Copayments, Deductible & Coinsurance	IN	OUT	IN	OUT	IN	OUT	
Copayments							
Office Visit	\$15*	50%	\$30*	50%	\$35*	50%	
Inpatient Copay	Individual	_____		None	_____		
	Family	_____		N/A	_____		
Outpatient Surgery Copay	_____		_____		None	_____	
ER Copay (waived if admitted)	\$100	\$100	\$150	\$150	\$200	\$200	
Deductible							
Deductible PCY	Individual	\$1,000	\$2,000	\$750	\$1,500	\$0	\$250
	Family	\$3,000	\$6,000	\$2,250	\$4,500	\$0	\$750
Coinsurance							
Coinsurance		20%	50%	25%	50%	35%*	50%
Out-of-Pocket Maximum PCY**	Individual	\$5,000	None	\$4,000	None	\$7,500	None
	Family	\$15,000	None	\$12,000	None	\$22,500	None
Covered Services	IN	OUT	IN	OUT	IN	OUT	
Office Visits – Professional Care							
Medical and Naturopathic Office Visits unlimited	\$15*	50%	\$30*	50%	\$35*	50%	
Spinal and Other Manipulations 12 visits PCY (chiropractic)	\$15*	50%	\$30*	50%	\$35*	50%	
Acupuncture 12 visits PCY	\$15*	50%	\$30*	50%	\$35*	50%	
Preventive Care unlimited							
Exams/Immunizations	_____		IN: \$0* OUT: Not covered		_____		
Preventive Screenings (includes mammography and colon health screenings)	_____		IN: \$0* OUT: 50%		_____		
Diagnostic Services							
Diagnostic Imaging/Laboratory	Paid in full to \$1,000 then Ded + Coin		_____		Ded + Coin _____		
Hospital/Facility Care							
Outpatient	_____		Ded + Coin		_____		
Inpatient	_____		Ded + Coin		_____		
Maternity – Prenatal/Postnatal Care	_____		Ded + Coin		_____		
Maternity – Delivery	_____		Ded + Coin		_____		
Emergency Care							
Professional / Facility	_____		ER Copay + Ded + Coin		_____		
Ambulance (air and ground)	_____		Ded + Coin		_____		
Mental Health Outpatient unlimited visits	\$15*	50%	\$30*	50%	\$35*	50%	
Mental Health Inpatient unlimited days	_____		Ded + Coin		_____		
Rehabilitation Outpatient A:30 visits PCY, B&C: 45 days PCY (PT, Massage, Speech, OT)	\$15*	50%	\$30*	50%	\$35*	50%	
Rehabilitation Inpatient A: 30 days PCY, B&C: 45 days PCY	_____		Ded + Coin		_____		
Prescription Drugs (participating pharmacies only)	Generic / Preferred Brand Name / Non-preferred Brand Name						
Rx Deductible (waived for generics) per person PCY	\$500		\$250		\$500		
Rx Out-of-Pocket Maximum per person PCY; includes Rx deductible, coinsurance and/or copay	_____		_____		\$5,000		
Retail Cost Share 30 day supply	\$0 / 30% / 30%		_____		\$0 / \$30 / \$45		
Mail Order Cost Share 90 day supply	\$0 / 25% / 25%		_____		\$0 / \$75 / \$112		
Specialty Drug Cost Share 30 day supply	_____		_____		30%		
Unum (Life & AD&D insurance) [†]	_____ \$20,000 decreasing term Life and AD&D for employee only _____						

* Not subject to the calendar year deductible

** Out-of-pocket maximum includes coinsurance and deductible. Covered in-network services paid at 100% of allowable charges for remainder of the calendar year once out-of-pocket maximum is met. No out-of-pocket maximum for out-of-network services.

† Unum is an independent provider of life insurance services that does not provide Premera Blue Cross products or services. Unum is solely responsible for its products and services.

NOTE: This summary is intended to assist you in decision making. Details of covered benefits, limitations, and exclusions are provided in the WEA Select Health Plan benefit booklets. This summary of benefits is not a contract.