

## WEA Select Medical Plans

Traditional PPO Networks			
Plan	Plan 2	Plan 3	Plan 5
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>Copayments / Deductible / Coinsurance</b>			
<b>COPAYMENTS</b>			
<b>Non-Specialist Copay</b>	Not subject to deductible <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> \$30 copayment per visit	Not subject to deductible <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$20 copayment per visit <b>Out-of-Network:</b> 70%
<b>Specialist Copay</b>	Not subject to deductible <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible <b>In-Network:</b> \$40 copayment per visit <b>Out-of-Network:</b> \$50 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 70%
<b>Inpatient Copay (per person)</b>	<b>In-Network:</b> \$150 per admission <i>[formerly \$150 per day / \$450 maximum per calendar year]</i> <b>Out-of-Network:</b> \$150 per admission <i>[formerly \$150 per day / \$450 maximum per calendar year]</i>	<b>In-Network:</b> \$300 per admission <i>[formerly \$300 per day / \$900 maximum per calendar year]</i> <b>Out-of-Network:</b> \$300 per admission <i>[formerly \$300 per day / \$900 maximum per calendar year]</i>	<b>In-Network:</b> \$150 per admission <i>[formerly \$150 per day / \$450 maximum per calendar year]</i> <b>Out-of-Network:</b> None
<b>Outpatient Surgery Copay</b>	<b>In-Network and Out-of-Network:</b> \$100	<b>In-Network and Out-of-Network:</b> \$150	<b>In-Network and Out-of-Network:</b> None
<b>ER Copay (waived if admitted)</b>	<b>In-Network and Out-of-Network:</b> \$75	<b>In-Network and Out-of-Network:</b> \$100	<b>In-Network and Out-of-Network:</b> \$50
<b>DEDUCTIBLE</b>			
<b>Deductible (per plan year)</b> <i>[formerly per calendar year]</i>  <b>Deductible—an amount you pay before the plan pays benefits</b>	<b>In-Network and Out-of-Network Combined:</b>  \$300 per individual \$900 per family  Deductible waived for office visits / preventive care	<b>In-Network and Out-of-Network Combined:</b>  \$500 per individual \$1,500 per family  Deductible waived for office visits / preventive care	<b>In-Network:</b> \$200 per individual \$600 per family <b>Out-of-Network:</b> \$350 per person  Deductible waived for in-network office visits / preventive care
<b>COINSURANCE</b>			
<b>Coinsurance</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 60% of allowable charges	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 60% of allowable charges	<b>In-Network:</b> 90% of allowable charges <b>Out-of-Network:</b> 70% of allowable charges

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### Traditional PPO Networks

Plan	Plan 2	Plan 3	Plan 5
<b>Provider Network</b>	<b>Aetna—Open Choice</b>	<b>Aetna—Open Choice</b>	<b>Aetna—Open Choice</b>
<b>Out-of-Pocket Maximum (OOPM)</b> <i>(per plan year) [formerly per calendar year]</i>	<b>In-Network:</b> \$2,000 per individual \$6,000 per family <b>Out-of-Network:</b> \$3,400 per individual \$10,200 per family	<b>In-Network:</b> \$3,000 per individual \$9,000 per family <b>Out-of-Network:</b> \$5,900 per individual \$17,700 per family	<b>In-Network:</b> \$1,000 per individual \$3,000 per family <b>Out-of-Network:</b> There is no out-of-pocket maximum for out-of-network providers
	<i>(After you reach this limit, the plan pays most benefits in full for the rest of the plan year, unless otherwise specified. Includes copays, deductible, and coinsurance. Excludes prescription drug copays.)</i>		
<b>Covered Services</b>			
<b>OFFICE VISITS—PROFESSIONAL CARE</b>			
<b>Medical and Naturopathic Office Visits (Unlimited)</b>	Not subject to deductible <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> \$30 copayment per visit	Not subject to deductible <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$20 copayment per visit <b>Out-of-Network:</b> 70%
<b>Spinal and Other Manipulations</b> <i>(52 visits per plan year)</i> <i>[formerly unlimited visits]</i>	Not subject to deductible <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> \$30 copayment per visit	Not subject to deductible <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$20 copayment per visit <b>Out-of-Network:</b> 70%
<b>Acupuncture (12 visits per plan year)</b> <i>[formerly per calendar year]</i> <b>Plan 5 (52 visits per plan year)</b> <i>[formerly unlimited for Plan 5]</i>	Not subject to deductible <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> \$30 copayment per visit	Not subject to deductible <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$20 copayment per visit <b>Out-of-Network:</b> 70%
<b>Telemedicine—NEW BENEFIT!</b>	<b>Not subject to deductible</b> Covered at 100% (in-network only)	<b>Not subject to deductible</b> Covered at 100% (in-network only)	<b>Not subject to deductible</b> Covered at 100% (in-network only)
<b>PREVENTIVE CARE</b>			
<b>Preventive Exams / Immunizations</b>	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 80%	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 80%	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> Not covered
<b>Preventive Screenings (included mammography and colon health screenings)</b>	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 80%	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 80%	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> Not covered

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Traditional PPO Networks			
Plan	Plan 2	Plan 3	Plan 5
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>DIAGNOSTIC SERVICES</b>			
Diagnostic Imaging / Laboratory	Subject to deductible  <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	Subject to deductible  <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	Subject to deductible  <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%
<b>HOSPITAL / FACILITY CARE</b>			
Outpatient Surgery / Ambulatory Surgery Centers	\$100 copayment; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$150 copayment; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	Subject to deductible <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%
Inpatient	\$150 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$300 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$150 copayment per admission (in-network only); subject to deductible <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%
<b>MATERNITY</b>			
Prenatal Care <i>[formerly covered the same as Postnatal Care]</i>	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 60% (subject to deductible)	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 60% (subject to deductible)	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 70% (subject to deductible)
Postnatal Care	Subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	Subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	Subject to deductible <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%
Delivery (newborns have their own copays / deductibles / coinsurance)	See Outpatient or Inpatient Hospital / Facility Care	See Outpatient or Inpatient Hospital / Facility Care	See Outpatient or Inpatient Hospital / Facility Care
<b>EMERGENCY CARE</b>			
Professional / Facility (copayment waived if admitted directly from Emergency Room)	\$75 copay per visit; subject to deductible and coinsurance	\$100 copay per visit; subject to deductible and coinsurance	\$50 copay per visit; subject to deductible and coinsurance
Ambulance—Air / Ground	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance

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Traditional PPO Networks			
Plan	Plan 2	Plan 3	Plan 5
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>OTHER SERVICES</b>			
<b>Outpatient Mental Health Care (unlimited visits)</b>	Not subject to deductible <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> \$30 copayment per visit	Not subject to deductible <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> \$40 copayment per visit	Not subject to deductible for in-network <b>In-Network:</b> \$20 copayment per visit <b>Out-of-Network:</b> 70% of allowed charges; subject to deductible
<b>Inpatient Mental Health Care (unlimited days)</b>	\$150 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$300 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$150 copayment per admission (in-network only); subject to deductible <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%
<b>Outpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (80 visits per plan year for Plans 2 and 3) [formerly covered at 45 visits per calendar year with PT unlimited] (45 visits per plan year for Plan 5) [formerly per calendar year]</b>	Not subject to deductible <b>In-Network:</b> \$35 copayment <b>Out-of-Network:</b> \$40 copayment <b>PT</b> —subject to deductible / coinsurance	Not subject to deductible <b>In-Network:</b> \$40 copayment <b>Out-of-Network:</b> \$50 copayment <b>PT</b> —subject to deductible / coinsurance	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment <b>Out-of-Network:</b> 70% of allowed charge; subject to deductible
<b>Inpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (no day limit) [formerly 120 day limit per calendar year for Plan 2 and 30 day limit per calendar year for Plans 3 and 5]</b>	\$150 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$300 copayment per admission; subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 60%	\$150 copayment per admission (in-network only); subject to deductible <b>In-Network:</b> 90% <b>Out-of-Network:</b> 70%

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### Traditional PPO Networks

Plan	Plan 2	Plan 3	Plan 5
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>Prescription Drugs (participating pharmacies)</b>			
<b>Rx Deductible</b>	None	None	None
<b>Rx Out-of-Pocket Maximum [1] (includes Rx copays / deductible)</b>	\$2,000 per individual \$4,000 per family	\$2,000 per individual \$4,000 per family	\$2,000 per individual \$4,000 per family
<b>Retail Prescription Drugs Most Generics / Preferred / Non-Preferred</b>	<b>Supply Limit:</b> Up to 34-days <b>Cost Share:</b> \$10 / \$20 / \$35	<b>Supply Limit:</b> Up to 34-days <b>Cost Share:</b> \$15 / \$25 / \$40	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$10 / \$15 / \$30
<b>Mail Order Prescription Drugs Most Generics / Preferred / Non-Preferred</b>	<b>Supply Limit:</b> Up to 100-days <b>Cost Share:</b> \$20 / \$40 / \$65	<b>Supply Limit:</b> Up to 100-days <b>Cost Share:</b> \$30 / \$50 / \$70	<b>Supply Limit:</b> Up to 90-days <b>Cost Share:</b> \$20 / \$30 / \$60
<b>Specialty Prescription Drugs</b>	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$50 copay	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$60 copay	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$50 copay
<b>Life Insurance</b>	\$12,500 term life and AD&D insurance for employee only	\$12,500 term life and AD&D insurance for employee only	\$12,500 term life and AD&D insurance for employee only

[1] Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the plan year.  
There is no out-of-pocket maximum for Plans 5, EasyChoice A, B and Basic for out-of-network services.

## WEA Select Medical Plans

Traditional PPO Networks			
Plan	EasyChoice A	EasyChoice B	Basic
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>Copayments / Deductible / Coinsurance</b>			
<b>COPAYMENTS</b>			
<b>Non-Specialist Copay</b>	Not subject to deductible for in-network <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50%
<b>Specialist Copay</b>	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$40 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$50 copayment per visit <b>Out-of-Network:</b> 50%
<b>Inpatient Copay (per person)</b>	None	None	None
<b>Outpatient Surgery Copay</b>	None	None	None
<b>ER Copay (waived if admitted)</b>	<b>In-Network and Out-of-Network:</b> \$100	<b>In-Network and Out-of-Network:</b> \$150	<b>In-Network and Out-of-Network:</b> \$200
<b>DEDUCTIBLE</b>			
<b>Deductible (per plan year)</b> <i>[formerly per calendar year]</i>  <i>Deductible—an amount you pay before the plan pays benefits</i>	<b>In-Network:</b> \$1,250 per individual \$3,750 per family <b>Out-of-Network:</b> \$2,000 per individual \$6,000 per family Deductible waived for office visits / preventive care	<b>In-Network:</b> \$750 per individual \$2,250 per family <b>Out-of-Network:</b> \$1,500 per individual \$4,500 per family Deductible waived for office visits / preventive care	<b>In-Network:</b> \$2,100 per individual \$4,200 per family <b>Out-of-Network:</b> \$2,500 per individual \$5,000 per family Deductible waived for office visits / preventive care
<b>COINSURANCE</b>			
<b>Coinsurance</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	<b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	<b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges

## WEA Select Medical Plans

Traditional PPO Networks			
Plan	EasyChoice A	EasyChoice B	Basic
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>Out-of-Pocket Maximum (OOPM)</b> <i>(per plan year) [formerly per calendar year]</i>  <b>Basic Only—Shared with Rx OOPM</b>	<b>In-Network:</b> \$4,000 per individual \$8,000 per family <b>Out-of-Network:</b> There is no out-of-pocket maximum for out-of-network providers	<b>In-Network:</b> \$3,500 per individual \$7,000 per family <b>Out-of-Network:</b> There is no out-of-pocket maximum for out-of-network providers	<b>In-Network:</b> \$6,600 per individual \$13,200 per family <b>Out-of-Network:</b> There is no out-of-pocket maximum for out-of-network providers
	<i>(After you reach this limit, the plan pays most benefits in full for the rest of the plan year, unless otherwise specified. Includes copays, deductible, and coinsurance.)</i>		
<b>Covered Services</b>			
<b>OFFICE VISITS—PROFESSIONAL CARE</b>			
<b>Medical and Naturopathic Office Visits (Unlimited)</b>	Not subject to deductible for in-network <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50%
<b>Spinal and Other Manipulations (12 visits per plan year) [formerly per calendar year]</b>	Not subject to deductible for in-network <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50%
<b>Acupuncture (12 visits per plan year) [formerly per calendar year]</b>	Not subject to deductible for in-network <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 50%	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50%
<b>Telemedicine—NEW BENEFIT!</b>	<b>Not subject to deductible</b> Covered at 100% (in-network only)	<b>Not subject to deductible</b> Covered at 100% (in-network only)	<b>Not subject to deductible</b> Covered at 100% (in-network only)
<b>PREVENTIVE CARE</b>			
<b>Preventive Exams / Immunizations</b>	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> Not covered	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> Not covered	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> Not covered
<b>Preventive Screenings (included mammography and colon health screenings)</b>	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 50% (subject to deductible)	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 50% (subject to deductible)	Not subject to deductible <b>In-Network:</b> 100% <b>Out-of-Network:</b> 50% (subject to deductible)

## WEA Select Medical Plans

Traditional PPO Networks			
Plan	EasyChoice A	EasyChoice B	Basic
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>DIAGNOSTIC SERVICES</b>			
<b>Diagnostic Imaging / Laboratory</b>	100% coinsurance up to \$250 (not subject to deductible); then subject to deductible and coinsurance <b>In-Network:</b> 80% <b>Out-of-Network:</b> 50%	Subject to deductible  <b>In-Network:</b> 75% <b>Out-of-Network:</b> 50%	Subject to deductible  <b>In-Network:</b> 70% <b>Out-of-Network:</b> 50%
<b>HOSPITAL / FACILITY CARE</b>			
<b>Outpatient Surgery / Ambulatory Surgery Centers</b>	Subject to deductible <b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Inpatient</b>	Subject to deductible <b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>MATERNITY</b>			
<b>Prenatal Care</b> <i>[formerly covered the same as Postnatal Care]</i>	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 50% (subject to deductible)	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 50% (subject to deductible)	<b>In-Network:</b> <b>100%</b> <b>Out-of-Network:</b> 50% (subject to deductible)
<b>Postnatal Care</b>	Subject to deductible <b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Delivery</b> (newborns have their own copays / deductibles / coinsurance)	Subject to deductible <b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>EMERGENCY CARE</b>			
<b>Professional / Facility</b> (copayment waived if admitted directly from Emergency Room)	\$100 copay per visit; subject to deductible and coinsurance	\$150 copay per visit; subject to deductible and coinsurance	\$200 copay per visit; subject to deductible and coinsurance
<b>Ambulance—Air / Ground</b>	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance



## WEA Select Medical Plans

Traditional PPO Networks			
Plan	EasyChoice A	EasyChoice B	Basic
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>OTHER SERVICES</b>			
<b>Outpatient Mental Health Care (unlimited visits)</b>	Not subject to deductible for in-network <b>In-Network:</b> \$25 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible	Not subject to deductible for in-network <b>In-Network:</b> \$30 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible
<b>Inpatient Mental Health Care (unlimited days)</b>	Subject to deductible <b>In-Network:</b> 80% <b>Out-of-Network:</b> 50%	Subject to deductible <b>In-Network:</b> 75% <b>Out-of-Network:</b> 50%	Subject to deductible <b>In-Network:</b> 70% <b>Out-of-Network:</b> 50%
<b>Outpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (30 visits per plan year for EasyChoice A and Basic) <i>[formerly per calendar year]</i> (45 visits per plan year for EasyChoice B) <i>[formerly per calendar year]</i></b>	Not subject to deductible for in-network <b>In-Network:</b> \$35 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible	Not subject to deductible for in-network <b>In-Network:</b> \$40 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible	Not subject to deductible for in-network <b>In-Network:</b> \$50 copayment per visit <b>Out-of-Network:</b> 50% of allowed charges; subject to deductible
<b>Inpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (no day limit) <i>[formerly 30 day limit per calendar year for EasyChoice A and Basic and 45 day limit per calendar year for EasyChoice B]</i></b>	Subject to deductible <b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 75% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges	Subject to deductible <b>In-Network:</b> 70% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges

## WEA Select Medical Plans

Traditional PPO Networks			
Plan	EasyChoice A	EasyChoice B	Basic
Provider Network	Aetna—Open Choice	Aetna—Open Choice	Aetna—Open Choice
<b>Prescription Drugs (participating pharmacies)</b>			
<b>Rx Deductible (per person per plan year)</b>	\$500 (waived for generics)	\$250 (waived for generics)	<b>In-Network:</b> \$750 per individual \$1,500 per family <b>Out-of-Network:</b> Not covered
<b>Rx Out-of-Pocket Maximum [1] (includes Rx copays / deductible / coinsurance)</b>	\$2,500 per individual \$5,000 per family	\$2,500 per individual \$5,000 per family	Shared with medical out-of-pocket maximum
<b>Retail Drugs Generic / Preferred / Non-Preferred</b>	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$10 / 30% / 30%	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$5 / \$30 / \$45	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> \$15 / \$30 / \$50
<b>Mail Order Drugs Generic / Preferred / Non-Preferred</b>	<b>Supply Limit:</b> Up to 90-days <b>Cost Share:</b> \$20 / 30% / 30%	<b>Supply Limit:</b> Up to 90-days <b>Cost Share:</b> \$10 / \$75 / \$112	<b>Supply Limit:</b> Up to 90-days <b>Cost Share:</b> \$30 / \$60 / \$100
<b>Specialty Drugs</b>	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> 30%	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> 30%	<b>Supply Limit:</b> Up to 30-days <b>Cost Share:</b> 30%
<b>Life Insurance</b>	\$12,500 term life and AD&D insurance for employee only	\$12,500 term life and AD&D insurance for employee only	\$12,500 term life and AD&D insurance for employee only

[1] Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the plan year. There is no out-of-pocket maximum for Plans 5, EasyChoice A, B and Basic for out-of-network services.

# WEA Select Medical Plans

Traditional PPO Networks	
Plan	QHDHP
Provider Network	Aetna—Open Choice
<b>Cost Shares</b>	
<b>DEDUCTIBLE</b>	
<p><b>Deductible (per plan year) [formerly per calendar year]</b></p> <p><i>(When a plan covers one or more dependents, benefits will not begin for any family members until the family deductible is met.)</i></p>	<p><b>In-Network:</b> \$1,750 per individual \$3,500 per family</p> <p><b>Out-of-Network:</b> \$3,000 per individual \$6,000 per family</p>
<b>COINSURANCE</b>	
<p><b>Coinsurance</b></p>	<p><b>In-Network:</b> 80% of allowable charges</p> <p><b>Out-of-Network:</b> 50% of allowable charges</p>
<p><b>Out-of-Pocket Maximum (per plan year) [formerly per calendar year]</b></p>	<p><b>In-Network:</b> \$5,000 per individual \$10,000 per family</p> <p><b>Out-of-Network:</b> There is no out-of-pocket maximum for out-of-network providers</p>
<p><i>(After you reach the out-of-pocket maximum, the plan pays most benefits in full for the rest of the plan year, unless otherwise specified. Includes deductible and coinsurance for medical and prescription drug. Services will be covered in full for any family members meeting their individual out-of-pocket maximum, even if the family out-of-pocket maximum is not met.)</i></p>	
<b>Covered Services</b>	
<b>PREVENTIVE CARE</b>	
<p><b>Exams / Immunizations</b></p>	<p>Not subject to deductible</p> <p><b>In-Network:</b> 100%</p> <p><b>Out-of-Network:</b> Not covered</p>
<p><b>Preventive Screenings</b></p>	<p>Not subject to deductible</p> <p><b>In-Network:</b> 100%</p> <p><b>Out-of-Network:</b> 50% of allowable charges (subject to deductible)</p>
<p><b>Telemedicine—NEW BENEFIT!</b></p>	<p><b>100% of allowable charges (in-network only)</b></p>

## WEA Select Medical Plans

Traditional PPO Networks	
Plan	QHDHP
Provider Network	Aetna—Open Choice
<b>PROFESSIONAL CARE</b>	
<b>Office Visit</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Outpatient Professional Services</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Inpatient Professional Services</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>ALTERNATIVE CARE</b>	
<b>Manipulations—Spinal and Other</b> (12 visits <i>per plan year</i> ) <i>[formerly per calendar year]</i>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Acupuncture (12 visits <i>per plan year</i>) <i>[formerly per calendar year]</i></b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Naturopathic Services</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>DIAGNOSTIC SERVICES</b>	
<b>Mammography—Non-Preventive</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>Outpatient Diagnostic Imaging and Laboratory Services</b>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges

## WEA Select Medical Plans

Traditional PPO Networks	
Plan	QHDHP
Provider Network	Aetna—Open Choice
<b>EMERGENCY CARE</b>	
Emergency Care	<b>In-Network and Out-of-Network:</b> 80% of allowable charges
Ambulance—Air / Ground	<b>In-Network and Out-of-Network:</b> 80% of allowable charges
<b>FACILITY CARE</b>	
Inpatient Care	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
Outpatient Facility Care	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>MATERNITY</b>	
Prenatal Care <i>[formerly covered the same as postnatal care]</i>	Not subject to deductible
	<b>In-Network:</b> <b>100% of allowable charges</b> <b>Out-of-Network:</b> 50% of allowable charges (subject to deductible)
Postnatal Care / Delivery (newborns have their own deductibles and coinsurance)	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
<b>OTHER SERVICES</b>	
Mental Health Care—Inpatient / Outpatient	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges
Rehabilitation—Occupational / Speech / Massage / Physical Therapy Outpatient—15 visits <i>per plan year [formerly per calendar year]</i> Inpatient—(No day limit) <i>[formerly 30 days per calendar year]</i>	<b>In-Network:</b> 80% of allowable charges <b>Out-of-Network:</b> 50% of allowable charges

## WEA Select Medical Plans

Traditional PPO Networks	
Plan	QHDHP
Provider Network	Aetna—Open Choice
Prescription Drugs (subject to medical deductible) [1]	
<b>Retail Prescription Drugs</b>	<b>Supply Limit:</b> Up to 30-days <b>In-Network and Out-of-Network:</b> 80% of allowable charges
<b>Mail Order Prescription Drugs</b>	<b>Supply Limit:</b> Up to 90-days <b>In-Network and Out-of-Network:</b> 80% of allowable charges
<b>Specialty Prescription Drugs</b>	<b>Supply Limit:</b> Up to 30-days <b>In-Network and Out-of-Network:</b> 80% of allowable charges
<b>Life Insurance</b>	\$12,500 term life and AD&D insurance for employee only

[1] A few generic prescription drugs are not subject to deductible and are covered in full.