WEA Select Medical Plans

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

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
Out-of-Pocket Maximum (OOPM) **(per plan year)** ***[formerly per calendar year]***	**In-Network:** $2,000 per individual $6,000 per family **Out-of-Network:** $3,400 per individual $10,200 per family	**In-Network:** $3,000 per individual $9,000 per family **Out-of-Network:** $5,900 per individual $17,700 per family	**In-Network:** $1,000 per individual $3,000 per family **Out-of-Network:** There is no out-of-pocket maximum for out-of-network providers
	(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.)		
Covered Services			
OFFICE VISITS—PROFESSIONAL CARE			
Medical and Naturopathic Office Visits (Unlimited)	Not subject to deductible **In-Network:** $25 copayment per visit **Out-of-Network:** $30 copayment per visit	Not subject to deductible **In-Network:** $30 copayment per visit **Out-of-Network:** $40 copayment per visit	Not subject to deductible for in-network **In-Network:** $20 copayment per visit **Out-of-Network:** 70%
Spinal and Other Manipulations **(52 visits per plan year)** ***[formerly unlimited visits]***	Not subject to deductible **In-Network:** $25 copayment per visit **Out-of-Network:** $30 copayment per visit	Not subject to deductible **In-Network:** $30 copayment per visit **Out-of-Network:** $40 copayment per visit	Not subject to deductible for in-network **In-Network:** $20 copayment per visit **Out-of-Network:** 70%
Acupuncture (12 visits per plan year) ***[formerly per calendar year]*** **Plan 5 (52 visits per plan year)** ***[formerly unlimited for Plan 5]***	Not subject to deductible **In-Network:** $25 copayment per visit **Out-of-Network:** $30 copayment per visit	Not subject to deductible **In-Network:** $30 copayment per visit **Out-of-Network:** $40 copayment per visit	Not subject to deductible for in-network **In-Network:** $20 copayment per visit **Out-of-Network:** 70%
Telemedicine—NEW BENEFIT!	**Not subject to deductible Covered at 100% (in-network only)**	**Not subject to deductible Covered at 100% (in-network only)**	**Not subject to deductible Covered at 100% (in-network only)**
PREVENTIVE CARE			
Preventive Exams / Immunizations	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 80%	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 80%	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered
Preventive Screenings (included mammography and colon health screenings)	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 80%	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 80%	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
DIAGNOSTIC SERVICES			
Diagnostic Imaging / Laboratory	Subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	Subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	Subject to deductible **In-Network:** 90% **Out-of-Network:** 70%
HOSPITAL / FACILITY CARE			
Outpatient Surgery / Ambulatory Surgery Centers	$100 copayment; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$150 copayment; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	Subject to deductible **In-Network:** 90% **Out-of-Network:** 70%
Inpatient	$150 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$300 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$150 copayment per admission (in-network only); subject to deductible **In-Network:** 90% **Out-of-Network:** 70%
MATERNITY			
Prenatal Care ***[formerly covered the same as Postnatal Care]***	**In-Network:** **100%** **Out-of-Network:** 60% (subject to deductible)	**In-Network:** **100%** **Out-of-Network:** 60% (subject to deductible)	**In-Network:** **100%** **Out-of-Network:** 70% (subject to deductible)
Postnatal Care (newborns have their own copays / deductibles / coinsurance)	Subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	Subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	Subject to deductible **In-Network:** 90% **Out-of-Network:** 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
EMERGENCY CARE			
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

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
OTHER SERVICES			
Outpatient Mental Health Care (unlimited visits)	Not subject to deductible **In-Network:** $25 copayment per visit **Out-of-Network:** $30 copayment per visit	Not subject to deductible **In-Network:** $30 copayment per visit **Out-of-Network:** $40 copayment per visit	Not subject to deductible for in-network **In-Network:** $20 copayment per visit **Out-of-Network:** 70% of allowed charges; subject to deductible
Inpatient Mental Health Care (unlimited days)	$150 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$300 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$150 copayment per admission (in-network only); subject to deductible **In-Network:** 90% **Out-of-Network:** 70%
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]***	Not subject to deductible **In-Network:** $35 copayment **Out-of-Network:** $40 copayment **PT**—subject to deductible / coinsurance	Not subject to deductible **In-Network:** $40 copayment **Out-of-Network:** $50 copayment **PT**—subject to deductible / coinsurance	Not subject to deductible for in-network **In-Network:** $30 copayment **Out-of-Network:** 70% of allowed charge; subject to deductible
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]***	$150 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$300 copayment per admission; subject to deductible **In-Network:** 80% **Out-of-Network:** 60%	$150 copayment per admission (in-network only); subject to deductible **In-Network:** 90% **Out-of-Network:** 70%

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
Prescription Drugs (participating pharmacies)			
Rx Deductible	None	None	None
Rx Out-of-Pocket Maximum [1] (includes Rx copays / deductible)	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Retail Prescription Drugs Most Generics / Preferred / Non-Preferred	**Supply Limit:** Up to 34-days **Cost Share:** $10 / $20 / $35	**Supply Limit:** Up to 34-days **Cost Share:** $15 / $25 / $40	**Supply Limit:** Up to 30-days **Cost Share:** $10 / $15 / $30
Mail Order Prescription Drugs Most Generics / Preferred / Non-Preferred	**Supply Limit:** Up to 100-days **Cost Share:** $20 / $40 / $65	**Supply Limit:** Up to 100-days **Cost Share:** $30 / $50 / $70	**Supply Limit:** Up to 90-days **Cost Share:** $20 / $30 / $60
Specialty Prescription Drugs	**Supply Limit:** Up to 30-days **Cost Share:** $50 copay	**Supply Limit:** Up to 30-days **Cost Share:** $60 copay	**Supply Limit:** Up to 30-days **Cost Share:** $50 copay
Life Insurance	$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	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
Copayments / Deductible / Coinsurance			
COPAYMENTS			
Non-Specialist Copay	Not subject to deductible for in-network **In-Network:** $25 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $30 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50%
Specialist Copay	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $40 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $50 copayment per visit **Out-of-Network:** 50%
Inpatient Copay (per person)	None	None	None
Outpatient Surgery Copay	None	None	None
ER Copay (waived if admitted)	**In-Network and Out-of-Network:** $100	**In-Network and Out-of-Network:** $150	**In-Network and Out-of-Network:** $200
DEDUCTIBLE			
Deductible (per plan year) ***[formerly per calendar year]*** ***Deductible—an amount you pay before the plan pays benefits***	**In-Network:** $1,250 per individual $3,750 per family **Out-of-Network:** $2,000 per individual $6,000 per family Deductible waived for office visits / preventive care	**In-Network:** $750 per individual $2,250 per family **Out-of-Network:** $1,500 per individual $4,500 per family Deductible waived for office visits / preventive care	**In-Network:** $2,100 per individual $4,200 per family **Out-of-Network:** $2,500 per individual $5,000 per family Deductible waived for office visits / preventive care
COINSURANCE			
Coinsurance	**In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	**In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	**In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
Out-of-Pocket Maximum (OOPM) **(per plan year)** ***[formerly per calendar year]*** **Basic Only—Shared with Rx OOPM**	**In-Network:** $4,000 per individual $8,000 per family **Out-of-Network:** There is no out-of-pocket maximum for out-of-network providers	**In-Network:** $3,500 per individual $7,000 per family **Out-of-Network:** There is no out-of-pocket maximum for out-of-network providers	**In-Network:** $6,600 per individual $13,200 per family **Out-of-Network:** There is no out-of-pocket maximum for out-of-network providers
	(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.)		
Covered Services			
OFFICE VISITS—PROFESSIONAL CARE			
Medical and Naturopathic Office Visits (Unlimited)	Not subject to deductible for in-network **In-Network:** $25 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $30 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50%
Spinal and Other Manipulations (12 visits per plan year) ***[formerly per calendar year]***	Not subject to deductible for in-network **In-Network:** $25 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $30 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50%
Acupuncture (12 visits per plan year) ***[formerly per calendar year]***	Not subject to deductible for in-network **In-Network:** $25 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $30 copayment per visit **Out-of-Network:** 50%	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50%
Telemedicine—NEW BENEFIT!	**Not subject to deductible** **Covered at 100% (in-network only)**	**Not subject to deductible** **Covered at 100% (in-network only)**	**Not subject to deductible** **Covered at 100% (in-network only)**
PREVENTIVE CARE			
Preventive Exams / Immunizations	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered
Preventive Screenings (included mammography and colon health screenings)	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 50% (subject to deductible)	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 50% (subject to deductible)	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 50% (subject to deductible)

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
DIAGNOSTIC SERVICES			
Diagnostic Imaging / Laboratory	100% coinsurance up to $250 (not subject to deductible); then subject to deductible and coinsurance **In-Network:** 80% **Out-of-Network:** 50%	Subject to deductible **In-Network:** 75% **Out-of-Network:** 50%	Subject to deductible **In-Network:** 70% **Out-of-Network:** 50%
HOSPITAL / FACILITY CARE			
Outpatient Surgery / Ambulatory Surgery Centers	Subject to deductible **In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges
Inpatient	Subject to deductible **In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges
MATERNITY			
Prenatal Care ***[formerly covered the same as Postnatal Care]***	**In-Network:** **100%** **Out-of-Network:** 50% (subject to deductible)	**In-Network:** **100%** **Out-of-Network:** 50% (subject to deductible)	**In-Network:** **100%** **Out-of-Network:** 50% (subject to deductible)
Postnatal Care (newborns have their own copays / deductibles / coinsurance)	Subject to deductible **In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges
Delivery (newborns have their own copays / deductibles / coinsurance)	Subject to deductible **In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges
EMERGENCY CARE			
Professional / Facility (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
Ambulance—Air / Ground	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	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
OTHER SERVICES			
Outpatient Mental Health Care (unlimited visits)	Not subject to deductible for in-network **In-Network:** $25 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible	Not subject to deductible for in-network **In-Network:** $30 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible
Inpatient Mental Health Care (unlimited days)	Subject to deductible **In-Network:** 80% **Out-of-Network:** 50%	Subject to deductible **In-Network:** 75% **Out-of-Network:** 50%	Subject to deductible **In-Network:** 70% **Out-of-Network:** 50%
Outpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (30 visits per plan year for EasyChoice A and Basic) ***[formerly per calendar year]*** **(45 visits per plan year for EasyChoice B)** ***[formerly per calendar year]***	Not subject to deductible for in-network **In-Network:** $35 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible	Not subject to deductible for in-network **In-Network:** $40 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible	Not subject to deductible for in-network **In-Network:** $50 copayment per visit **Out-of-Network:** 50% of allowed charges; subject to deductible
Inpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy (no day limit) ***[formerly 30 day limit per calendar year for EasyChoice A and Basic and 45 day limit per calendar year for EasyChoice B)***	Subject to deductible **In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 75% of allowable charges **Out-of-Network:** 50% of allowable charges	Subject to deductible **In-Network:** 70% of allowable charges **Out-of-Network:** 50% of allowable charges

WEA Select Medical Plans

Traditional PPO Networks			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**	**UnitedHealthcare—Choice Plus**
Prescription Drugs (participating pharmacies)			
Rx Deductible **(per person per plan year)**	$500 (waived for generics)	$250 (waived for generics)	**In-Network:** $750 per individual $1,500 per family **Out-of-Network:** Not covered
Rx Out-of-Pocket Maximum [1] **(includes Rx copays / deductible / coinsurance)**	$2,500 per individual $5,000 per family	$2,500 per individual $5,000 per family	Shared with medical out-of-pocket maximum
Retail Drugs **Generic / Preferred / Non-Preferred**	**Supply Limit:** Up to 30-days **Cost Share:** $10 / 30% / 30%	**Supply Limit:** Up to 30-days **Cost Share:** $5 / $30 / $45	**Supply Limit:** Up to 30-days **Cost Share:** $15 / $30 / $50
Mail Order Drugs **Generic / Preferred / Non-Preferred**	**Supply Limit:** Up to 90-days **Cost Share:** $20 / 30% / 30%	**Supply Limit:** Up to 90-days **Cost Share:** $10 / $75 / $112	**Supply Limit:** Up to 90-days **Cost Share:** $30 / $60 / $100
Specialty Drugs	**Supply Limit:** Up to 30-days **Cost Share:** 30%	**Supply Limit:** Up to 30-days **Cost Share:** 30%	**Supply Limit:** Up to 30-days **Cost Share:** 30%
Life Insurance	$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	**UnitedHealthcare—Choice Plus**
Cost Shares	
DEDUCTIBLE	
Deductible (per plan year) *[formerly per calendar year]* *(When a plan covers one or more dependents, benefits will not begin for any family members until the family deductible is met.)*	**In-Network:** $1,750 per individual $3,500 per family **Out-of-Network:** $3,000 per individual $6,000 per family
COINSURANCE	
Coinsurance	**In-Network:** 80% of allowable charges **Out-of-Network:** 50% of allowable charges
Out-of-Pocket Maximum (per plan year) *[formerly per calendar year]*	**In-Network:** $5,000 per individual $10,000 per family **Out-of-Network:** There is no out-of-pocket maximum for out-of-network providers
(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.)	
Covered Services	
PREVENTIVE CARE	
Exams / Immunizations	Not subject to deductible **In-Network:** 100% **Out-of-Network:** Not covered
Preventive Screenings	Not subject to deductible **In-Network:** 100% **Out-of-Network:** 50% of allowable charges (subject to deductible)
Telemedicine—NEW BENEFIT!	**100% of allowable charges (in-network only)**

WEA Select Medical Plans

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

WEA Select Medical Plans

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

WEA Select Medical Plans

Traditional PPO Networks	
Plan	**QHDHP**
Provider Network	**UnitedHealthcare—Choice Plus**
Prescription Drugs (subject to medical deductible) [1]	
Retail Prescription Drugs	**Supply Limit:** Up to 30-days **In-Network and Out-of-Network:** 80% of allowable charges
Mail Order Prescription Drugs	**Supply Limit:** Up to 90-days **In-Network and Out-of-Network:** 80% of allowable charges
Specialty Prescription Drugs	**Supply Limit:** Up to 30-days **In-Network and Out-of-Network:** 80% of allowable charges
Life Insurance	$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.

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
Copayments / Deductible / Coinsurance			
COPAYMENTS			
Non-Specialist Copay	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $20 copayment per visit
	(Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.)		
Specialist Copay	Not subject to deductible $35 copayment per visit $50 copayment per visit for self-referrals	Not subject to deductible $40 copayment per visit $60 copayment per visit for self-referrals	Not subject to deductible $30 copayment per visit $50 copayment per visit for self-referrals
Inpatient Copay (per person)	**$150 per admission** ***[formerly $150 per day / $450 maximum per calendar year]***	**$300 per admission** ***[formerly $300 per day / $900 maximum per calendar year]***	**$150 per admission** ***[formerly $150 per day / $450 maximum per calendar year]***
Outpatient Surgery Copay	$100	$150	None
ER Copay (waived if admitted)	$75	$100	$50
DEDUCTIBLE			
Deductible (per plan year) ***[formerly per calendar year]*** ***Deductible—an amount you pay before the plan pays benefits***	$300 per individual $900 per family Deductible waived for office visits / preventive care	$500 per individual $1,500 per family Deductible waived for office visits / preventive care	$200 per individual $600 per family Deductible waived for office visits / preventive care
COINSURANCE			
Coinsurance	80% of allowable charges	80% of allowable charges	90% of allowable charges
Out-of-Pocket Maximum (OOPM) **(per plan year)** ***[formerly per calendar year]***	$2,000 per individual $6,000 per family	$3,000 per individual $9,000 per family	$1,000 per individual $3,000 per family
	(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 copays, deductible, and coinsurance. Excludes prescription drug copays.)		
Covered Services			
OFFICE VISITS—PROFESSIONAL CARE			
Medical and Naturopathic Office Visits (Unlimited)	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $20 copayment per visit
Spinal and Other Manipulations **(52 visits per plan year)** ***[formerly unlimited visits]***	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $20 copayment per visit
Acupuncture (12 visits per plan year) ***[formerly per calendar year]*** **Plan 5 (52 visits per plan year)** ***[formerly unlimited for Plan 5]***	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $20 copayment per visit
Telemedicine—NEW BENEFIT!	**Not subject to deductible** **Covered at 100%**	**Not subject to deductible** **Covered at 100%**	**Not subject to deductible** **Covered at 100%**

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
PREVENTIVE CARE			
Preventive Exams / Immunizations	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Preventive Screenings (included mammography and colon health screenings)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
DIAGNOSTIC SERVICES			
Diagnostic Imaging / Laboratory	Subject to deductible 80%	Subject to deductible 80%	Subject to deductible 90%
HOSPITAL / FACILITY CARE			
Outpatient Surgery / Ambulatory Surgery Centers	$100 copayment, subject to deductible 80%	$150 copayment, subject to deductible 80%	Subject to deductible 90%
Inpatient	$150 copayment per admission; subject to deductible 80%	$300 copayment per admission; subject to deductible 80%	$150 copayment per admission; subject to deductible 90%
MATERNITY			
Prenatal Care ***[formerly covered the same as Postnatal Care]***	**100%**	**100%**	**100%**
Postnatal Care (newborns have their own copays / deductibles / coinsurance)	Subject to deductible 80%	Subject to deductible 80%	Subject to deductible 90%
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
EMERGENCY CARE			
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
OTHER SERVICES			
Outpatient Mental Health Care (unlimited visits)	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $20 copayment per visit
Inpatient Mental Health Care (unlimited days)	$150 copayment per admission; subject to deductible 80%	$300 copayment per admission; subject to deductible 80%	$150 copayment per admission; subject to deductible 90%

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**Plan 2**	**Plan 3**	**Plan 5**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
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]***	Not subject to deductible $35 copayment **PT**—subject to deductible / coinsurance	Not subject to deductible $40 copayment **PT**—subject to deductible / coinsurance	Not subject to deductible $30 copayment
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]***	$150 copayment per admission; subject to deductible 80%	$300 copayment per admission; subject to deductible 80%	$150 copayment per admission; subject to deductible 90%
Prescription Drugs (participating pharmacies)			
Rx Deductible	None	None	None
Rx Out-of-Pocket Maximum [1] (includes Rx copays / deductible)	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family	$2,000 per individual $4,000 per family
Retail Prescription Drugs **Most Generics / Preferred / Non-Preferred**	**Supply Limit:** Up to 34-days **Cost Share:** $10 / $20 / $35	**Supply Limit:** Up to 34-days **Cost Share:** $15 / $25 / $40	**Supply Limit:** Up to 30-days **Cost Share:** $10 / $15 / $30
Mail Order Prescription Drugs **Most Generics / Preferred / Non-Preferred**	**Supply Limit:** Up to 100-days **Cost Share:** $20 / $40 / $65	**Supply Limit:** Up to 100-days **Cost Share:** $30 / $50 / $70	**Supply Limit:** Up to 90-days **Cost Share:** $20 / $30 / $60
Specialty Prescription Drugs	**Supply Limit:** Up to 30-days **Cost Share:** $50 copay	**Supply Limit:** Up to 30-days **Cost Share:** $60 copay	**Supply Limit:** Up to 30-days **Cost Share:** $50 copay
Life Insurance	$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 services are paid at 100% of allowable charges for the remainder of the plan year.

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
Copayments / Deductible / Coinsurance			
COPAYMENTS			
Non-Specialist Copay	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $35 copayment per visit
	(Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.)		
Specialist Copay	Not subject to deductible $35 copayment per visit $50 copayment per visit for self-referrals	Not subject to deductible $40 copayment per visit $60 copayment per visit for self-referrals	Not subject to deductible $50 copayment per visit $75 copayment per visit for self-referrals
Inpatient Copay (per person)	None	None	None
Outpatient Surgery Copay	None	None	None
ER Copay (waived if admitted)	$100	$150	$200
DEDUCTIBLE			
Deductible (per plan year) ***[formerly per calendar year]*** ***Deductible—an amount you pay before the plan pays benefits***	$1,250 per individual $3,750 per family Deductible waived for office visits / preventive care	$750 per individual $2,250 per family Deductible waived for office visits / preventive care	$2,100 per individual $4,200 per family Deductible waived for office visits / preventive care
COINSURANCE			
Coinsurance	80% of allowable charges	75% of allowable charges	70% of allowable charges
Out-of-Pocket Maximum (OOPM) (per plan year) ***[formerly per calendar year]***	$4,000 per individual $8,000 per family	$3,500 per individual $7,000 per family	$6,600 per individual $13,200 per family
Basic Only—Shared with Rx OOPM	*(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 copays, deductible, and coinsurance.)*		
Covered Services			
OFFICE VISITS—PROFESSIONAL CARE			
Medical and Naturopathic Office Visits (Unlimited)	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $35 copayment per visit
Spinal and Other Manipulations (12 visits per plan year) ***[formerly per calendar year]***	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $35 copayment per visit
Acupuncture (12 visits per plan year) ***[formerly per calendar year]***	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $35 copayment per visit
Telemedicine—NEW BENEFIT!	**Not subject to deductible** **Covered at 100%**	**Not subject to deductible** **Covered at 100%**	**Not subject to deductible** **Covered at 100%**

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
PREVENTIVE CARE			
Preventive Exams / Immunizations	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Preventive Screenings (included mammography and colon health screenings)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
DIAGNOSTIC SERVICES			
Diagnostic Imaging / Laboratory	100% coinsurance up to $250 (not subject to deductible); then subject to deductible and coinsurance 80%	Subject to deductible 75%	Subject to deductible 70%
HOSPITAL / FACILITY CARE			
Outpatient Surgery / Ambulatory Surgery Centers	Subject to deductible 80% of allowable charges	Subject to deductible 75% of allowable charges	Subject to deductible 70% of allowable charges
Inpatient	Subject to deductible 80% of allowable charges	Subject to deductible 75% of allowable charges	Subject to deductible 70% of allowable charges
MATERNITY			
Prenatal Care *[formerly covered the same as Postnatal Care]*	**100%**	**100%**	**100%**
Postnatal Care	Subject to deductible 80%	Subject to deductible 75%	Subject to deductible 70%
Delivery (newborns have their own copays / deductibles / coinsurance)	Subject to deductible 80%	Subject to deductible 75%	Subject to deductible 70%
EMERGENCY CARE			
Professional / Facility (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
Ambulance—Air / Ground	Subject to deductible and coinsurance	Subject to deductible and coinsurance	Subject to deductible and coinsurance
OTHER SERVICES			
Outpatient Mental Health Care (unlimited visits)	Not subject to deductible $25 copayment per visit	Not subject to deductible $30 copayment per visit	Not subject to deductible $35 copayment per visit
Inpatient Mental Health Care (unlimited days)	Subject to deductible 80%	Subject to deductible 75%	Subject to deductible 70%

WEA Select Medical Plans

High Performance Networks In-Network Coverage Only			
Plan	**EasyChoice A**	**EasyChoice B**	**Basic**
Provider Network	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**	**UnitedHealthcare—Navigate Balanced**
Outpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy **(30 visits per plan year for EasyChoice A and Basic)** ***[formerly per calendar year]*** **(45 visits per plan year for EasyChoice B)** ***[formerly per calendar year]***	Not subject to deductible $35 copayment per visit	Not subject to deductible $40 copayment per visit	Not subject to deductible $50 copayment per visit
Inpatient Rehabilitation—Occupational / Speech / Massage / Physical Therapy **(no day limit)** ***[formerly 30 day limit per calendar year for EasyChoice A and Basic and 45 day limit per calendar year for EasyChoice B)***	Subject to deductible 80% of allowable charges	Subject to deductible 75% of allowable charges	Subject to deductible 70% of allowable charges
Prescription Drugs (participating pharmacies)			
Rx Deductible **(per person per plan year)**	$500 (waived for generics)	$250 (waived for generics)	$750 per individual $1,500 per family
Rx Out-of-Pocket Maximum [1] **(includes Rx copays / deductible / coinsurance)**	$2,500 per individual $5,000 per family	$2,500 per individual $5,000 per family	Shared with medical out-of-pocket maximum
Retail Drugs **Generic / Preferred / Non-Preferred**	**Supply Limit:** Up to 30-days **Cost Share:** $10 / 30% / 30%	**Supply Limit:** Up to 30-days **Cost Share:** $5 / $30 / $45	**Supply Limit:** Up to 30-days **Cost Share:** $15 / $30 / $50
Mail Order Drugs **Generic / Preferred / Non-Preferred**	**Supply Limit:** Up to 90-days **Cost Share:** $20 / 30% / 30%	**Supply Limit:** Up to 90-days **Cost Share:** $10 / $75 / $112	**Supply Limit:** Up to 90-days **Cost Share:** $30 / $60 / $100
Specialty Drugs	**Supply Limit:** Up to 30-days **Cost Share:** 30%	**Supply Limit:** Up to 30-days **Cost Share:** 30%	**Supply Limit:** Up to 30-days **Cost Share:** 30%
Life Insurance	$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 services are paid at 100% of allowable charges for the remainder of the plan year.

WEA Select Medical Plans

High Performance Networks	
In-Network Coverage Only	
Plan	**QHDHP**
Provider Network	**UnitedHealthcare—Navigate Balanced**
Cost Shares	
DEDUCTIBLE	
Deductible (per plan year) *[formerly per calendar year]* *(When a plan covers one or more dependents, benefits will not begin for any family members until the family deductible is met.)*	$1,750 per individual $3,500 per family
COINSURANCE	
Coinsurance	80% of allowable charges
Out-of-Pocket Maximum (per plan year) *[formerly per calendar year]*	$5,000 per individual $10,000 per family
(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.)	
Covered Services	
PREVENTIVE CARE	
Exams / Immunizations	Not subject to deductible 100%
Preventive Screenings	Not subject to deductible 100%
Telemedicine—NEW BENEFIT!	**100% of allowable charges**
PROFESSIONAL CARE	
Office Visit	80% of allowable charges
(Each enrolled person must select a PCP. Your PCP must be in an area where you (the subscriber) lives. Your PCP will be your first point of contact when you need care.)	
Outpatient Professional Services	80% of allowable charges
Inpatient Professional Services	80% of allowable charges
ALTERNATIVE CARE	
Manipulations—Spinal and Other (12 visits per plan year) *[formerly per calendar year]*	80% of allowable charges
Acupuncture (12 visits per plan year) *[formerly per calendar year]*	80% of allowable charges
Naturopathic Services	80% of allowable charges
DIAGNOSTIC SERVICES	
Mammography—Non-Preventive	80% of allowable charges
Outpatient Diagnostic Imaging and Laboratory Services	80% of allowable charges

WEA Select Medical Plans

High Performance Networks	
In-Network Coverage Only	
Plan	**QHDHP**
Provider Network	**UnitedHealthcare—Navigate Balanced**
EMERGENCY CARE	
Emergency Care	80% of allowable charges
Ambulance—Air / Ground	80% of allowable charges
FACILITY CARE	
Inpatient Care	80% of allowable charges
Outpatient Facility Care	80% of allowable charges
MATERNITY	
Prenatal Care ***[formerly covered the same as postnatal care]***	Not subject to deductible **100% of allowable charges**
Postnatal Care / Delivery **(newborns have their own deductibles and coinsurance)**	80% of allowable charges
OTHER SERVICES	
Mental Health Care—Inpatient / Outpatient	80% of allowable charges
Rehabilitation—Occupational / Speech / Massage / Physical Therapy **Outpatient—15 visits per plan year** ***[formerly per calendar year]*** **Inpatient—(No day limit) [formerly 30 days per calendar year]**	80% of allowable charges
Prescription Drugs (subject to medical deductible) [1]	
Retail Prescription Drugs	**Supply Limit:** Up to 30-days **Cost Share:** 80% of allowable charges
Mail Order Prescription Drugs	**Supply Limit:** Up to 90-days **Cost Share:** 80% of allowable charges
Specialty Prescription Drugs	**Supply Limit:** Up to 30-days **Cost Share:** 80% of allowable charges
Life Insurance	$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.