



WBACC Trust

Plan Comparison

March 1, 2008 - February 28, 2009



Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Plan Option	PPO 1, 2, 4 100/80/80/50	PPO 5 70/70/50	FourFront Plans 100-80/80/50	Selections 100 - 100/70/15	H S A Qualified Plan 80/80/60
				Selections 80 - 80/50/15	
Deductible Individual / Family per calendar year (PCY)	PPO 1 - \$200/\$600 PPO 2 - \$400/\$1,200 PPO 4 - \$500/\$1,500	\$500/\$1,500	FF 200 - \$200/\$600 FF 500 - \$500/\$1,500 FF 750 - \$750/\$2,250 FF 1000 - \$1,000/\$3,000	\$0/\$0 Network \$200/\$600 Extended \$100/\$300 Network \$200/\$600 Extended	\$1,500/\$3,000 Entire family deductible must be met prior to benefits being paid for any family member
Coinsurance Maximum Individual / Family per calendar year	PPO 1 - \$3,000/\$9,000 PPO 2 - \$3,000/\$9,000 PPO 4 - \$3,000/\$9,000	\$3,000/\$9,000	FF 200 - \$2,500/\$7,500 FF 500 - \$2,500/\$7,500 FF 750 - \$5,000/\$15,000 FF 1000 - \$5,000/\$15,000	\$2,500/\$7,500 Network \$10,000/\$30,000 Extended \$2,500/\$7,500 Network \$10,000/\$30,000 Extended	\$5,000/\$10,000 Entire family coinsurance max must be met prior to benefits being paid for any family member
Copay Per Office Visit	PPO 1 - \$25 PPO 2 - \$25 PPO 4 - \$30	No Copay	\$25 All plans	\$15 \$15 Copay 80% / 50%	No copay
Professional Services	PPO/Participating	PPO/Participating	PPO/Participating	Selections Network / Extended Network	PPO/Participating
Office Visit	100% / 50% Not subject to deductible when copay applies	70% / 50% Deductible waived	100% / 50% First 4 office, home & O/P hospital visits PCY are <u>not</u> subject to deductible 80% / 50% 5th & subsequent visits are subject to ded. as are other services <u>not</u> billed as an office visit	\$15 Copay / 70% \$15 Copay 80% / 50%	80% / 60%
Outpatient Diagnostic Lab & X-ray (Includes mammograms & PSA tests)	80% / 50% Deductible waived when billed as a preferred professional office visit	70% / 50%	100% / 50% First \$500 PCY is <u>not</u> subject to ded. 80% / 50% Charges above \$500 PCY are subject to ded.	100% / 70% 80% / 50%	80% / 60%
Hospital Facility Inpatient care (including I/P & O/P Lab & X-ray) Emergency Room - copay waived if admitted	80% / 50% \$150 Copay, 80% / 50%	70% / 50% \$150 Copay, 70% / 50%	80% / 50% \$75 Copay, 80% / 50%	100% / 70%; ER - \$75 copay 80% / 50%; ER - \$150 copay	80% / 60% 80% / 60%
Preventive Care Annual exam, well baby care, immunizations, pap smears, cancer screening (no deductible)	100% / 50%, \$400 max	70% / 50%, \$400 max	100% / 50%, \$300 max	\$15 Copay / Mammo only 70% \$15 Copay 80% / Mammo only 50%	80% / 60%, \$300 max Deductible waived
Other Services					
Transplants - \$250,000 lifetime max \$50,000 per transplant donor organ procurement \$2,500 per transplant travel & lodging max	80% / 50% 6-month waiting period	70% / 50% 6-month waiting period	80% / 50% 6-month waiting period	100% / no coverage - 12-month w/p 80% / no coverage - 12-month w/p	80% / 60% 6-month waiting period
Mental Health Inpatient days PCY Outpatient visits PCY	80% / 50% - 8 days 80% / 50% - 12 visits	70% / 50% - 8 days 70% / 50% - 12 visits	80% / 50% - 8 days 80% / 50% - 12 visits	100% - 12 days / 70% - 6 days \$15 - 100% 15 visits / 70% - 12 visits 80% - 12 days / 50% - 6 days \$15 - 80% 15 visits / 50% - 12 visits	80% / 60% - 8 days 80% / 60% - 12 visits
Chemical Dependency - \$14,000 max every 2 cal yrs	100%/50%; copay applies	70%/50%	80%/50%	100%/70% - 80%/50%	80% / 60%
Rehabilitation Max per condition Inpatient / max Outpatient PCY (Does not apply to the coinsurance max amount)	80% / 50% PPO 1 - \$30,000/\$3,000 PPO 2 - \$30,000/\$2,500 PPO 4 - \$30,000/\$1,500	70% / 50% \$30,000/\$1,500	80% / 50% \$30,000/\$1,500	100% / 70%; \$30,000 max per cond. \$15 / 70% PCY; \$1,000 max 80% / 50%; \$30,000 max per cond. \$15 80% / 50%, \$1,000 max	80% / 60% \$30,000 max per condition I/P 80% / 60%; \$1,500 max O/P
Spinal Manipulations - 10 manipulations PCY	80% / 50%	70% / 50%	80% / 50%	\$15 copay - 100%/70% / 80%/50%	80% / 60%
Acupuncture - 12 visits PCY	80% / 50%	70% / 50%	80% / 50%	\$15 copay - 100%/70% / 80% / 50%	80% / 60%
Prescription Drug - Generic / Brand / Non-formulary					
Retail	\$10/\$35/\$70	\$10/\$35/\$70 - 150 ded. Waived on generics	FF 200, 500, 750 - \$10/\$35/\$70 FF 1000 - \$10/35/70 - \$150 ded. Waived on generics	\$10/\$35/\$70 \$10/\$35/\$70 - \$150 ded. Waived on generics. Must use approved pharmacies	80% for all prescriptions Regence BlueShield reimburses member
Mail Order - 90-day supply - \$20/\$70/\$140					

All plans have a \$2,000,000 lifetime maximum

This is a brief summary of benefits. For full coverage provisions, including waiting periods & exclusions, please refer to the benefit brochure & contract filed with the WBACC Trust.