WBACC Trust
Plan Comparison
March 1, 2009 - February 28, 2010

Plan Option	PPO 200, 400, 500A 100/80/80/50	PPO 500B 70/70/50	FourFront Plans 100-80/80/50	Selections 100 - 100/70/15 Selections 80 - 80/50/15	H S A Qualified Plan 80/80/60
Deductible Individual / Family per calendar year (PCY)	PPO 200 - $200/$600 PPO 400 - $400/$1,200 PPO 500A - $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 200 - $3,000/$9,000 PPO 400 - $3,000/$9,000 PPO 500A - $3,000/$9,000	$3,000/$9,000	FF 200 - $2,500/$7,500 FF 500 - $2,500/$7,500 FF 750 - $2,500/$7,500 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 200 - $25 PPO 400 - $25 PPO 500A - $30	No Copay	$25 All plans	15 Copay 100% $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 not subject to deductible 80% / 50% 5th & subsequent visits are subject to ded. as are other services not billed as an office visit	$15 Copay 100% / 70% $15 Copay 80% / 50%	80% / 60%
Outpatient Diagnostic Lab & X-ray **(Includes diagnostic mammograms & PSA tests)**	80% / 50% **Deductible waived when billed as a professional office visit**	70% / 50%	100% / 50% First $500 PCY is not 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 (not subject to deductible) Annual exam, well baby care, immunizations, pap smears, routine cancer screening	100% / 50%, **Unlimited**	70% / 50%, **Unlimited**	100% / 50%, **Unlimited**	$15 Copay 100% / Mammo only 70% $15 Copay 80% / Mammo only 50%	80% / 60%, **Unlimited** 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 - $14,500 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 200 - $30,000/$3,000 PPO 400 - $30,000/$2,500 PPO 500A - $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 Mail Order - 90-day supply - $20/$70/$140	$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

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.