



2007 Plan Year Benefit Comparison

Underwritten by Asuris Northwest Health

Plan Options	PPO 1, 2 & 4 100/80/80/50	PPO 3 & 5 70/70/50	Advance 1,000 100- 70/70/50	Advance 500 100- 70/70/50	HSA Qualified PPO 80/80/60
Deductible Individual/Family per calendar year	PPO 1 - \$200/\$600 PPO 2 - \$300/\$900 PPO 4 - \$500/\$1,500	PPO 3 - \$300/\$900 PPO 5 - \$500/\$1,500	\$1,000 / \$3,000	\$500 / \$1,500	\$1,500/\$3,000 Entire family deductible must be met prior to benefits being paid to any member
Out-of-pocket maximum Individual/Family per calendar year	PPO 1 - \$2,500/\$7,500 PPO 2 - \$2,500/\$7,500 PPO 4 - \$2,500/\$7,500	PPO 3 - \$5,000/\$15,000 PPO 5 - \$2,500/\$7,500	\$5,000 / \$15,000	\$2,500 / \$7,500	\$5,000/\$10,000 Entire family out-of-pocket maximum must be met prior to benefits being paid in full to any member
Copay Per office visit	PPO 1 - \$20 PPO 2 - \$25 PPO 4 - \$25	No copay	\$20 office visit copay	\$20 office visit copay	No copay
Plan Benefits					
Professional Services	Preferred / Participating	Preferred / Participating	Preferred / Participating	Preferred / Participating	Preferred / Participating
Office Visit	100% / 50% Not subject to the deductible when copay applies.	70% /50% PPO 3 - subject to deductible PPO 5 - deductible waived	100% / 50% (not subject to the deductible) First 4 office, home or outpatient hospital visits per calendar year 70% / 50% (subject to deductible) Fifth & subsequent office, home or outpatient hospital visits per calendar year & other services not billed as an office visit	100% / 50% (not subject to the deductible) First 4 office, home or outpatient hospital visits per calendar year 70% / 50% (subject to the deductible) Fifth & subsequent office, home or outpatient hospital visits per calendar year & other services not billed as an office visit	80% /60%
Outpatient Diagnostic Lab & X-ray	80% / 50% subject to deductible	70% /50% PPO 3 - subject to deductible PPO 5 - deductible waived	100% / 50% (not subject to the deductible) First \$500 per cal. year 70% / 50% (subject to deductible) Charges above \$500 per cal. year	100% / 50% (not subject to the deductible) First \$500 per cal. year 70% / 50% (subject to deductible) Charges above \$500 per cal. year	80% /60%
Hospital Facility					
Inpatient Care (including inpatient and outpatient Diagnostic Lab & X-ray)	80% / 50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Emergency Room - \$75 Copay, waived if admitted	80% / 50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Preventive Care					
Annual Exam, well baby care, immunizations & cancer Screening (not subject to deductible, except PPO 3)	100% / 50%, \$400 Max.	70% /50% PPO 3 - unlimited/subject to ded. PPO 5 - \$400 max.	100% / 50%, \$300 max.	100% / 50%, \$300 max.	80% /60%, \$300 max.
Other Services					
Transplants 6-month waiting period \$250,000 lifetime maximum \$50,000 per transplant donor organ procurement maximum \$2,500 per transplant travel & lodging	80% / 50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Mental Disorders 8 Inpatient days per cal. year 12 Outpatient visits per calendar year**	80% /50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Chemical Dependency \$13,500 maximum every 2 cal. years	100% / 50%	70% / 50%	70% / 50%	70% / 50%	80% /60%
Rehabilitation Maximum per condition inpatient / Maximum per calendar year outpatient**	80% /50% PPO 1 - \$30,000 / \$2,500 PPO 2 - \$30,000 / \$2,500 PPO 4 - \$30,000 / \$1,500	70% /50% PPO 3 - \$30,000 / \$2,500 PPO 5 - \$30,000 / \$1,500	70% /50% \$30,000 / \$1,500	70% / 50% \$30,000 / \$1,500	80% /60% \$30,000 / \$1,500
Spinal Manipulations 10 manipulations per calendar year	80% / 50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Acupuncture 12 visits per calendar year	80% / 50%	70% /50%	70% / 50%	70% / 50%	80% /60%
Prescription Drug - Generic / Brand Name / Non-formulary Copay					
Retail	PPO 1 - \$10/\$20/\$40 All Others - 5/\$25/\$50	PPO 3 - \$12/30%/50% PPO 5 - \$5/\$25/\$50	\$10/\$20/\$40	\$10/\$20/\$40	80% for all prescriptions Regence BlueShield Reimburses Member
Mail Order	PPO 1 - \$20/\$40/\$80 All others - \$10/\$50/\$100	PPO 3 - \$24/30%/50% PPO 5 - \$10/\$50/\$100	\$20/\$40/\$80	\$20/\$40/\$80	
Lifetime Maximum	\$2,000,000				
** Benefits do not apply to the out of pocket coinsurance amount This is a brief summary of benefits. For full coverage provisions, including a description of waiting periods, limitations, & exclusions, refer to the benefit brochure & contract filed with the WBACC					



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Plan Options	Traditional 50/50
Deductible Individual/Family per calendar year	\$0 Deductible
Out-of-pocket maximum Individual/Family per calendar year	\$5,000/\$15,000
Copay	No copay
Plan Benefits	
Professional Services	Participating
Office Visit	50%
Outpatient Diagnostic Lab & X-ray	50%
Hospital Facility	
Inpatient Care (including inpatient and outpatient Diagnostic Lab & X-ray)	50%
Emergency Room - \$75 copay, waived if admitted	50%
Preventive Care	
Annual Exam, well baby care, immunizations & cancer Screening - not subject to the deductible	50%, \$300 max
Other Services	
Transplants 6-month waiting period \$250,000 lifetime maximum \$50,000 per transplant donor organ procurement maximum \$2,500 per transplant travel & lodging	50%
Mental Disorders 8 Inpatient days per calendar year 12 Outpatient visits per calendar year	50%
Chemical Dependency \$13,500 every 2 calendar years	50%
Rehabilitation Maximum per condition inpatient / Maximum per calendar year outpatient**	50% \$30,000 / \$1,500
Spinal Manipulations 10 manipulation limit per calendar year	50%
Acupuncture 12 visits per calendar year	50%
Prescription Drug - Generic / Brand Name / Non-formulary Copay	
Retail	\$10/\$20/\$40
Mail Order	\$20/\$40/\$80
Lifetime Maximum	\$2,000,000
** Benefits do not apply to the out of pocket coinsurance amount This is a brief summary of benefits. For full coverage provisions, including a description of waiting periods, limitations, & exclusions, refer to the benefit brochure & contract filed with the WBACC	