



COMPARISON OF MEDICAL PLANS

2010 Plan Year

Proof 7 11/30 014251 LJK

WBBA BENEFIT PROGRAM

Cost shares represent what you pay

| MEDICAL PLAN | PLAN A | PLAN B | PLAN C |
|--|---|---|--|
| Network | Heritage +1 | Heritage +1 | Heritage +1 |
| Individual Deductible PCY Family 3x Individual | \$0 In-Network / \$200 Out-of-Network | \$200 Shared In and Out | \$250 Shared In and Out |
| Coinsurance ¹ In-network / Out-of-network after Deductible | 0% / 50% | 0% / 50% | 10% / 50% |
| Out-Of-Pocket Maximum Out-of-pocket maximum is per calendar year and includes deductible. Excludes copays. Family x 3. | \$0 In-Network / \$10,200 Out-of-Network | \$2,700 Shared In and Out | \$2,750 Shared In and Out |
| Office Visit Copay ² | \$20 In-Network | \$15 In-Network | \$20 In-Network |
| COVERED SERVICES³ | | | |
| PREVENTIVE CARE⁴ (In-network Only) | Unlimited | Unlimited | Unlimited |
| Preventive Care Office Visit | \$20 copay | \$15 copay | \$20 copay |
| Immunizations | Covered in full | Covered in full | Covered in full |
| Health Education, Community Wellness and Diabetes Education (HE/CW to \$250 PCY) | Covered in full | Covered in full | Covered in full |
| Smoking Cessation (to \$500 PCY) | Covered in full | Covered in full | Covered in full |
| PROFESSIONAL CARE/DIAGNOSTIC SERVICES | | | |
| Office Visit (Includes 1 routine vision and hearing exam PCY in Plans A, B, C & D). Includes Urgent Care Visit. | \$20 copay | \$15 copay | \$20 copay |
| Outpatient Professional Services | 0% / 50% | 0% / 50% | 10% / 50% |
| Inpatient Professional Services | 0% / 50% | 0% / 50% | 10% / 50% |
| Diagnostic Imaging & Laboratory Services | 0% / 50% | 0% / 50% | 10% / 50% |
| Mammography | 0% / 50% | 0% / 50% | 10% / 50% |
| FACILITY CARE | | | |
| Inpatient Care | 0% / 50% | 0% / 50% | 10% / 50% |
| Skilled Nursing Facility | 0% / 50%: 90 days PCY | 0% / 50%: 60 days PCY | 10% / 50%: 60 days PCY |
| Outpatient Surgery Facility | 0% / 50% | 0% / 50% | 10% / 50% |
| EMERGENCY CARE | | | |
| Emergency Room (Copay waived if admitted) | \$200 copay, then 0% | \$200 copay, then 0% | \$200 copay, then 10% |
| Outpatient Emergency Care | 0% | 0% | 10% |
| Ambulance Transportation | 0% | 0% | 10% |
| OTHER SERVICES | | | |
| Transplants (In-network only) ⁵ Outpatient: OV Copay or Coinsurance applies / \$350,000 Lifetime Max | Outpatient: \$20 OV copay Inpatient & Outpatient Surgery: 0% | Outpatient: \$15 OV copay Inpatient & Outpatient Surgery: 0% | Outpatient: \$20 OV copay Inpatient & Outpatient Surgery: |
| Mental Health Care Outpatient and Inpatient: Unlimited | \$20 OV copay / 50% | \$15 OV copay / 50% | \$20 OV copay / 50% |
| Chemical Dependency Treatment Unlimited | Outpatient: \$20 OV copay Inpatient: 0% / 50% | Outpatient: \$15 OV copay Inpatient: 0% / 50% | Outpatient: \$20 OV copay Inpatient: 10% / 50% |
| Rehabilitation 45 visits PCY Outpatient / 30 Days PCY Inpatient | Outpatient: \$20 OV copay Inpatient: 0% / 50% | Outpatient: \$15 OV copay Inpatient: 0% / 50% | Outpatient: \$20 OV copay Inpatient: 10% / 50% |
| Neurodevelopmental Therapy 45 visits PCY Outpatient / 30 Days PCY Inpatient | Outpatient: \$20 OV copay Inpatient: 0% / 50% | Outpatient: \$15 OV copay Inpatient: 0% / 50% | Outpatient: \$20 OV copay Inpatient: 10% / 50% |
| Hospice Care 6-month max. Inpatient: 10 days max; Respite: 240 hours max | 0% / 50% | 0% / 50% | 10% / 50% |
| Home Health Care 130 visits PCY | 0% / 50% | 0% / 50% | 10% / 50% |
| Supplies, Equipment and Prosthetics \$10,000 PCY; Orthotics \$300 | 0% / 50% | 0% / 50% | 10% / 50% |
| Spinal and Other Manipulations | \$20 OV copay / 50% 24 visit limit PCY | \$15 OV copay / 50% 24 visit limit PCY | \$20 OV copay / 50% 24 visit limit PCY |
| Acupuncture 12 visits PCY | \$20 OV copay / 50% | \$15 OV copay / 50% | \$20 OV copay / 50% |
| Naturopathic Services | \$20 OV copay / 50% | \$15 OV copay / 50% | \$20 OV copay / 50% |
| Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime Max | Outpatient: \$20 OV copay Inpatient: 0% / 50% | Outpatient: \$15 OV copay Inpatient: 0% / 50% | Outpatient: \$20 OV copay Inpatient: 10% / 50% |
| PRESCRIPTION Rx | GENERIC / PREFERRED / NON-PREFERRED | GENERIC / PREFERRED / NON-PREFERRED | GENERIC / PREFERRED / NON-PREFERRED |
| Retail 30-day supply | \$10 / \$25 / \$50 | \$10 / \$25 / \$50 | \$10 / \$25 / \$50 |
| Mail Order 90-day supply | \$20 / \$50 / \$100 | \$20 / \$50 / \$100 | \$20 / \$50 / \$100 |
| LIFETIME BENEFIT MAXIMUM | \$2 Million | \$2 Million | \$2 Million |

PCY = Per Calendar Year

OV = Office Visit

¹ All coinsurance amounts based on % of allowable charges after deductible is met.

² Deductible waived when OV copay applies.

³ Benefits listed apply after calendar-year deductible is met, unless otherwise specified.

⁴ Deductible waived.

⁵ 6-month waiting period, subject to being waived for prior creditable coverage.

| | PLAN D | PLAN E | PLAN F | PLAN G |
|-----|---|---|---|---|
| | Heritage +1 | Heritage +1 | Heritage +1 | Heritage +1 |
| | \$300 Shared In and Out | \$500 Shared In and Out | \$750 Shared In and Out | \$1,000 Shared In and Out |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | \$1,800 Shared In and Out | \$3,000 Shared In and Out | \$3,000 Shared In and Out | \$5,000 Shared In and Out |
| | \$20 In-Network | \$25 In-Network | \$25 In-Network | \$30 |
| | Unlimited | Unlimited | Unlimited | Unlimited |
| | \$20 copay | \$25 copay | \$25 copay; 0% | \$30 OV Copay |
| | Covered in full | Covered in full | Covered in full | Covered in full |
| | Covered in full | Covered in full | Covered in full | Covered in full |
| | Covered in full | Covered in full | Covered in full | Covered in full |
| | \$20 copay | \$25 copay | \$25 copay | \$30 OV Copay |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50% | Covered in full | 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50%; 60 days PCY | 20% / 50%; 60 days PCY | 20% / 50%; 60 days PCY | 20% / 50%; 60 days PCY |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | \$200 copay, then 20% | \$200 Copay, then 20% | \$200 copay, then 20% | \$200 copay, then Ded. / 20% |
| | 20% | 20% | 20% | 20% |
| | 20% | 20% | 20% | 20% |
| 10% | Outpatient: \$20 OV copay; Inpatient & Outpatient Surgery: 20% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | 20% |
| | \$20 OV copay / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | 20% / 50% |
| | Outpatient: \$20 OV copay; Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | 20% / 50% |
| | Outpatient: \$20 OV copay; Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | 20% / 50%; Outpatient: \$30 OV copay |
| | Outpatient: \$20 OV copay; Inpatient: 20% / 50% | Outpatient: \$25 copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50% |
| | 20% / 50% | 20% / 50% | 20% / 50% | 20% / 50%; \$10,000; \$300 Orthotics PCY shared with MS/ME/Prosthetics |
| | \$20 OV copay / 50%: 12 visit limit PCY | \$25 OV copay: 12 visit limit PCY | \$25 OV copay / 50% 12 visit limit PCY | \$30 OV Copay / 50% 12 visit limit PCY |
| | \$20 OV copay / 50% | \$25 OV copay | \$25 OV copay / 50% | \$30 OV Copay / 50% |
| | \$20 OV copay / 50% | \$25 OV copay / 50% | \$25 OV copay / 50% | \$30 OV Copay / 50% |
| | Outpatient: \$20 OV copay; Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$25 OV copay / 50% Inpatient: 20% / 50% | Outpatient: \$30 OV Copay / 50% Inpatient: 20% / 50% |
| RR | GENERIC / PREFERRED / NON-PREFERRED | GENERIC / PREFERRED / NON-PREFERRED | GENERIC / PREFERRED / NON-PREFERRED | GENERIC / PREFERRED / NON-PREFERRED |
| | \$10 / \$25 / \$50 | \$10 / \$30 / \$60 | \$10 / \$30 / \$60 | \$10 / \$35 / \$70 |
| | \$20 / \$50 / \$100 | \$20 / \$60 / \$120 | \$20 / \$60 / \$120 | \$20 / \$70 / \$140 |
| | \$2 Million | \$2 Million | \$2 Million | \$2 Million |

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³ Benefits listed apply after calendar-year deductible is met, unless otherwise specified.

⁴ Deductible waived.

⁵ 6-month waiting period, subject to being waived for prior creditable coverage.

WBBA BENEFIT PROGRAM

Cost shares represent what you pay

| MEDICAL PLAN | PLAN I | PLAN HSA \$1,700 | PLAN HSA \$2,500 |
|---|---|---|---|
| Network | Heritage +1 | Heritage +1 | Heritage +1 |
| Individual Deductible PCY | \$2,000 Shared In and Out | \$1,700 Individual / \$3,400 Family Aggregate Deductible | \$2,500 Individual / \$5,000 Family Aggregate Deductible |
| Coinsurance ¹ In-network / Out-of-network after Deductible | 20% / 50% | 20% / 50% | 20% / 50% |
| Out-Of-Pocket Maximum Out-of-pocket maximum is per calendar year and includes deductible. Excludes copays. | \$5,000 Shared In and Out | \$4,200 Individual / \$8,400 Family Aggregate | \$5,000 Individual / \$10,000 Family Aggregate |
| Office Visit Copay ² | \$30 In-Network | Deductible and Coinsurance | N/A; Subject to major medical |
| COVERED SERVICES³ | | | |
| PREVENTIVE CARE⁴ (In-network Only) | Unlimited | Unlimited | Unlimited |
| Preventive Care Office Visit | \$30 copay; 0% | 20% ⁴ | 20% ⁴ |
| Immunizations | Covered in full | 20% ⁴ | 20% ⁴ |
| Health Education, Community Wellness and Diabetes Education (HE/CW to \$250 PCY) | Covered in full | Not covered except for Diabetes Education | Not covered except for Diabetes Education |
| Smoking Cessation (to \$500 PCY) | Covered in full | Not covered | Not covered |
| PROFESSIONAL CARE/DIAGNOSTIC SERVICES | | | |
| Office Visit (Includes 1 routine vision and hearing exam PCY in Plans A, B, C & D). Includes Urgent Care Visit | \$30 copay | 20% / 50% | 20% / 50% |
| Outpatient Professional Services | 20% / 50% | 20% / 50% | 20% / 50% |
| Inpatient Professional Services | 20% / 50% | 20% / 50% | 20% / 50% |
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| FACILITY CARE | | | |
| Inpatient Care | 20% / 50% | 20% / 50% | 20% / 50% |
| Skilled Nursing Facility | 20% / 50%: 60 days PCY | 20% / 50%: 60 days PCY | 20% / 50%: 60 days PCY |
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| EMERGENCY CARE | | | |
| Emergency Room (Copay waived if admitted) | \$200 copay, then 20% | 20% | 20% |
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| Rehabilitation Inpatient: 30 days PCY | Outpatient: \$30 OV copay / 50% Inpatient: 20% / 50% | 20% / 50%: Outpatient: 15 visits PCY | 20% / 50%: Outpatient: 15 visits PCY |
| Neurodevelopmental Therapy Inpatient: 30 days PCY | Outpatient: \$30 OV copay / 50% Inpatient: 20% / 50% | 20% / 50%: Outpatient: 15 visits PCY | 20% / 50%: Outpatient: 15 visits PCY |
| Hospice Care 6-month maximum | 20% / 50% | 20% / 50% | 20% / 50% |
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| Supplies, Equipment and Prosthetics | 20% / 50% | 20% / 50%; \$2,500; \$300 Orthotics PCY shared with MS/ME/Prosthetics | 20% / 50%; \$2,500; \$300 Orthotics PCY shared with MS/ME/Prosthetics |
| Spinal and Other Manipulations 12 visits PCY | \$30 OV copay / 50% 12 visit limit PCY | 20% / 50% | 20% / 50% |
| Acupuncture 12 visits PCY | \$30 OV copay / 50% | 20% / 50% | 20% / 50% |
| Naturopathic Services | \$30 OV copay / 50% | 20% / 50% | 20% / 50% |
| Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime Max | Outpatient: \$30 OV copay / 50% Inpatient: 20% / 50% | Not covered | Not covered |
| PRESCRIPTION Rx | | | |
| Retail 30-day supply | GENERIC / PREFERRED / NON-PREFERRED \$10 / \$35 / \$70 | MAJOR MEDICAL 20% | MAJOR MEDICAL 20% |
| Mail Order 90-day supply | \$20 / \$70 / \$140 | 20% | 20% |
| LIFETIME BENEFIT MAXIMUM | \$2 Million | \$2 Million | \$2 Million |

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⁵ 6-month waiting period, subject to being waived for prior creditable coverage.



Program Management Provided by:
Wells Fargo Insurance Services

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