

Northwest Employers Trust



Regence

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

All Plans Effective July 1, 2009 or on group renewal date thereafter

Underwritten by Regence BlueShield

Medical Plan Options	<u>\$250 Deductible PPO</u> <u>\$500 Deductible PPO</u> (100/80/80/50/\$25)	<u>\$750 Deductible PPO</u> <u>\$1,000 Deductible PPO</u> (100/80/80/50/\$30)	<u>\$1,500 Deductible PPO</u> <u>\$2,000 Deductible PPO</u> <u>\$2,500 Deductible PPO</u> (100/80/80/50/\$35)	HSA Qualified PPO 80/80/60
Deductible (Individual/Family) per calendar year	<u>\$250 Deductible PPO</u> (\$250 / \$750) <u>\$500 Deductible PPO</u> (\$500 / \$1,500)	<u>\$750 Deductible PPO</u> (\$750 / \$2,250) <u>\$1,000 Deductible PPO</u> (\$1,000 / \$3,000)	<u>\$1,500 Deductible PPO</u> (\$1,500 / \$4,500) <u>\$2,000 Deductible PPO</u> (\$2,000 / \$6,000) <u>\$2,500 Deductible PPO</u> (\$2,500 / \$7,500)	<u>\$1,500 Deductible HSA</u> (\$1,500 / \$3,000)
Out-of-pocket maximum (Individual/Family) per calendar year	\$3,000 / \$9,000	\$3,000 / \$9,000	\$3,000 / \$9,000	\$5,000 / \$10,000 (Deductible Included)
Copay (Per office visit on PPO plans)	\$25 copay	\$30 copay	\$35 copay	N/A
	Office visit copay applies for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department. Copay does not apply for surgery, radiation and chemotherapy, spinal manipulations or if Member directly admitted to hospital. Copay does not count toward any annual deductible or stoploss.			N/A
Lifetime Maximum	\$2,000,000			
Medical Plan Benefits				
Professional Services	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider
Office Visit	100% / 50% (Not subject to the deductible)	100% / 50% (Not subject to the deductible)	100% / 50% (Not subject to the deductible)	80% / 60% Deductible Applies
Outpatient Diagnostic Lab & X-ray	100% / 50% First \$500 per calendar year (Not subject to the deductible) 80% / 50% (Subject to the deductible) Charges above \$500 per calendar year	100% / 50% First \$500 per calendar year (Not subject to the deductible) 80% / 50% (Subject to the deductible) Charges above \$500 per calendar year	100% / 50% First \$500 per calendar year (Not subject to the deductible) 80% / 50% (Subject to the deductible) Charges above \$500 per calendar year	80% / 60% Deductible Applies
Other Professional Services	80% / 50% (Subject to the deductible)	80% / 50% (Subject to the deductible)	80% / 50% (Subject to the deductible)	80% / 60% Deductible Applies
Hospital Facility Services	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider
Inpatient Care (including inpatient and outpatient Diagnostic Lab & X-ray)	80% / 50%	80% / 50%	80% / 50%	80% / 60% Deductible Applies
Ambulatory Surgery Centers	80% / 50%	80% / 50%	80% / 50%	80% / 60%

Skilled Nursing Facility (90 day maximum)	80%	80%	80%	80%
Emergency Room (ER Copay waived if admitted)	80% / 50% \$150 ER Copay	80% / 50% \$150 ER Copay	80% / 50% \$150 ER Copay	80% / 60% No Emergency Room Copay
Preventive Care (professional and facility)	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider
Annual Exam, well baby care, immunizations & cancer screenings (Copay applies / not subject to the deductible)	100% / 50%, unlimited max	100% / 50%, unlimited max	100% / 50%, unlimited max	80% / 60% unlimited max
Other Services (professional and facility)	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider	Preferred / Participating / Recognized Provider
Transplants \$250,000 lifetime maximum \$50,000 per transplant donor organ procurement maximum \$2,500 per transplant travel & lodging	80% / 50%	80% / 50%	80% / 50%	80% / 60% \$250,000 lifetime maximum
Mental Disorders 8 Inpatient days per calendar year 12 Outpatient visits per calendar year**	80% / 50%	80% / 50%	80% / 50%	80% / 60%
Chemical Dependency \$14,500 maximum every two years	80% / 50%	80% / 50%	80% / 50%	80% / 60%
Rehabilitation \$30,000 per condition inpatient maximum \$1,500 per year outpatient maximum**	Inpatient 80% / 50% Outpatient 80% / 50%	Inpatient 80% / 50% Outpatient 80% / 50%	Inpatient 80% / 50% Outpatient 80%/50%	Inpatient 80% / 60% Outpatient 80% / 60%
Neurodevelopmental Therapy** For children age 6 & under \$1,500 per calendar year maximum	80% / 50%	80% / 50%	80% / 50%	80% / 60%
Home Health Care & Hospice Care 130 home health visits per calendar year maximum 6 months hospice max	80% / 80%	80% / 80%	80% / 80%	80% / 80%
Spinal Manipulations 10 spinal manipulation limit per calendar year maximum	80% / 50%	80% / 50%	80% / 50%	80% / 80%
Acupuncture 12 visits per calendar year maximum	80% / 50%	80% / 50%	80% / 50%	80% / 80%

Prescription Drugs	Retail Pharmacy 34-day supply (participating pharmacy)	Mail Order Pharmacy 90-day supply (participating pharmacy)
HSA \$1,500 Deductible PPO	80% (subject to medical plan deductible)	80% (subject to medical plan deductible)
\$250 Deductible PPO \$500 Deductible PPO	\$10 generic copay \$30 formulary name-brand copay \$60 non-formulary name-brand copay (not subject to medical plan deductible) (does not count toward coinsurance maximum)	\$20 generic copay \$60 formulary name-brand copay \$120 non-formulary name-brand copay (not subject to medical plan deductible) (does not count toward coinsurance maximum)
	<p align="center">Important Prescription Drug Information:</p> <p>If your prescription has an exact generic equivalent available and you select the brand-name medication, you will pay the name-brand drug copay <u>and</u> the difference in cost between the two medications at the time of purchase, but you will not pay more than the full retail cost of the brand-name medication.</p> <p align="center">The difference in cost will not count toward your deductible or coinsurance maximum.</p>	
\$750 Deductible PPO \$1,000 Deductible PPO \$1,500 Deductible PPO \$2,000 Deductible PPO \$2,500 Deductible PPO	\$12 generic copay \$40 formulary name-brand copay \$70 non-formulary name-brand copay (not subject to medical plan deductible) (does not count toward coinsurance maximum)	\$24 generic copay \$80 formulary name-brand copay \$140 non-formulary name-brand copay (not subject to medical plan deductible) (does not count toward coinsurance maximum)
	<p align="center">Important Prescription Drug Information:</p> <p>If your prescription has an exact generic equivalent available and you select the brand-name medication, you will pay the name-brand drug copay <u>and</u> the difference in cost between the two medications at the time of purchase, but you will not pay more than the full retail cost of the brand-name medication.</p> <p align="center">The difference in cost will not count toward your deductible or coinsurance maximum.</p>	
Vision Plans - Optional Benefit	(Medical deductible, office visit copay and stoploss do not apply to vision exam or hardware)	
PPO Plan Options	Eye Exam	Hardware
Vision Exam Only	One eye exam per calendar year Paid at 100%	No hardware benefit
Vision Exam and Hardware	One eye exam per calendar year Paid at 100%	Lenses and frames to paid at 80% to \$200 maximum every 2 calendar years.
Regence Life and Health	Minimum \$10,000 Employee Life and AD&D Benefit Optional \$15,000 or \$25,000 Employee Life AD&D also available	
AssistNET	Employee Assistance Program, Free and Confidential	
CareEnhance	24-hour nurse line. Included at no additional charge.	
Special Beginnings	Special Beginnings prenatal care / wellness program for pregnant women. Included at no additional charge.	