

Pacific Northwest Consulting Engineers
Health & Welfare Trust
2012 Medical plan comparison



Offering medical plan options to keep your members well.

	Plan 3 OP 10/10/20/1,700 250cd		Plan 5 OP 15/20/40/2,000 500cd		Plan 5 Plus OP 15/10/20/2,000 500cd	
	In plan	Out of plan	In plan	Out of plan	In plan	Out of plan
Calendar year combined deductible individual/family	\$250/\$750		\$500/\$1,500		\$500/\$1,500	
Calendar year combined out-of-pocket maximum	\$1,700/\$5,100 (excludes deductible)		\$2,000/\$6,000 (excludes deductible)		\$2,000/\$6,000 (excludes deductible)	
Lifetime maximum benefit	unlimited		unlimited		unlimited	
	You pay		You pay		You pay	
WOMEN'S HEALTH CARE SERVICES						
Gynecological exams (calendar year), Pap tests	Covered in full✓	20%✓	Covered in full✓	40%✓	Covered in full✓	20%✓
Mammograms	Covered in full✓	20%	Covered in full✓	40%	Covered in full✓	20%
PHYSICIAN/PROVIDER SERVICES						
Office visits	\$10/visit✓	20%✓	\$15/visit✓	40%✓	\$15/visit✓	20%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	20%✓	Covered in full✓	40%✓	Covered in full✓	20%✓
Inpatient hospital visits	10%	20%	20%	40%	10%	20%
Allergy shots, serums and injectable medications	10%	20%	20%	40%	10%	20%
Routine immunizations/shots	Covered in full✓	20%✓	Covered in full✓	40%✓	Covered in full✓	20%✓
HOSPITAL SERVICES						
Inpatient care	10%	20%	20%	40%	10%	20%
Maternity services						
Prenatal and postnatal visits; delivery	\$100/delivery✓	20%	\$150/delivery✓	40%	\$150/delivery✓	20%
Hospital services	10%	20%	20%	40%	10%	20%
Routine newborn nursery care	10%✓	20%	20%✓	40%	10%✓	20%
DURABLE MEDICAL EQUIPMENT						
Medical, diabetes supplies, appliances and prosthetics	10%*	20%	20%*	40%	10%*	20%
Emergency/Urgent Care and Ambulance Services						
Emergency services	\$250✓	\$250✓	\$250✓	\$250✓	\$250✓	\$250✓
Urgent care services	\$10/visit✓	20%✓	\$15/visit✓	40%✓	\$15/visit✓	20%✓
Emergency medical transportation	10%	10%	20%	20%	10%	10%
OTHER COVERED SERVICES						
X-ray and lab services	10%✓	20%	20%✓	40%	10%✓	20%
Outpatient rehabilitative services (30 visits per calendar year)	10%	20%	20%	40%	10%	20%
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	10%	20%	20%	40%	10%	20%

✓ No deductible needs to be met prior to receiving this benefit. *Deductible does not apply to diabetes supplies

This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).

2012 Medical plan comparison (cont.)

	Plan 7 OP 20/20/40/2,500 750cd		Plan 10 OP 25/20/30/2,500 1,000cd		Plan 25 OP 25/20/40/3,000 2,500cd	
	In plan	Out of plan	In plan	Out of plan	In plan	Out of plan
Calendar year common deductible individual/family	\$750/\$2,250		\$1,000/\$3,000		\$2,500/ \$7,500	
Calendar year common out-of-pocket maximum	\$2,500/\$7,500 (excludes deductible)		\$2,500/\$7,500 (excludes deductible)		\$3,000/ \$9,000 (excludes deductible)	
Lifetime maximum benefit	unlimited		unlimited		unlimited	
	You pay		You pay		You pay	
WOMEN'S HEALTH CARE SERVICES						
Gynecological exams(calendar year), Pap tests	Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Mammograms	Covered in full✓	40%	Covered in full✓	30%	Covered in full✓	40%
PHYSICIAN/PROVIDER SERVICES						
Office visits	\$20/visit✓	40%✓	\$25/visit✓	30%✓	\$25/visit✓	40%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Inpatient hospital visits	20%	40%	20%	30%	20%	40%
Allergy shots, serums and injectable medications	20%	40%	20%	30%	20%	40%
Routine immunizations/shots	Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
HOSPITAL SERVICES						
Inpatient care	20%	40%	20%	30%	20%	40%
Maternity services						
Prenatal and postnatal visits; delivery	\$200/delivery✓	40%	\$250/delivery✓	30%	\$250/ delivery✓	40%
Hospital services	20%	40%	20%	30%	20%	40%
Routine newborn nursery care	20%✓	40%	20%✓	30%	20%✓	40%
DURABLE MEDICAL EQUIPMENT						
Medical, diabetes supplies, appliances and prosthetics	20%*	40%	20%*	30%	20%*	40%
Emergency/Urgent Care and Ambulance Services						
Emergency services	\$250✓	\$250✓	\$250✓	\$250✓	\$250✓	\$250✓
Urgent care services	\$20/visit✓	40%✓	\$25/visit ✓	30%✓	\$25/visit	40%✓
Emergency medical transportation	20%	20%	20%	20%	20%	20%
OTHER COVERED SERVICES						
X-ray and lab services	20%✓	40%	20%✓	30%	20%✓	40%
Outpatient rehabilitative services (30 visits per calendar year)	20%	40%	20%	30%	20%	40%
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	20%	40%	20%	30%	20%	40%

✓ No deductible needs to be met prior to receiving this benefit. *Deductible does not apply to diabetes supplies.

This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).

2012 Medical plan comparison (cont.)

	Plan 5 Value CORE 25/30/50/3,000 500cd		Plan 7 Value CORE 25/30/50/3,000 750cd		Plan 10 Value CORE 25/30/50/\$3,000 1000cd	
	In plan	Out of plan	In plan	Out of plan	In plan	Out of plan
Calendar year common deductible individual/family	\$500/\$1,500		\$750/\$2,250		\$1,000/\$3,000	
Calendar year common out-of-pocket maximum	\$3,000/\$9,000 (excludes deductible)		\$3,000/\$9,000 (excludes deductible)		\$3,000/\$9,000 (excludes deductible)	
Lifetime maximum benefit	unlimited		unlimited		unlimited	
	You pay		You pay		You pay	
WOMEN'S HEALTH CARE SERVICES						
Gynecological exams (calendar year), Pap tests	Covered in full✓	50%✓	Covered in full✓	50%✓	Covered in full✓	50%✓
Mammograms	Covered in full✓	50%	Covered in full✓	50%	Covered in full✓	50%
PHYSICIAN/PROVIDER SERVICES						
Office visits to personal physician	\$25/visit✓	50%✓	\$25/visit✓	50%✓	\$25/visit✓	50%✓
Specialist visits	\$35/visit✓	50%✓	\$35/visit✓	50%✓	\$35/visit✓	50%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	50%✓	Covered in full✓	50%✓	Covered in full✓	50%✓
Inpatient hospital visits	30%	50%	30%	50%	30%	50%
Allergy shots, serums and injectable medications	30%	50%	30%	50%	30%	50%
Routine immunizations/shots	Covered in full✓	50%	Covered in full✓	50%	Covered in full✓	50%
HOSPITAL SERVICES						
Inpatient care	30%	50%	30%	50%	30%	50%
Maternity services						
Prenatal and postnatal visits; delivery	30%	50%	30%	50%	30%	50%
Hospital services	30%	50%	30%	50%	30%	50%
Routine newborn nursery care	30%	50%	30%	50%	30%	50%
DURABLE MEDICAL EQUIPMENT						
Medical, diabetes supplies, appliances and prosthetics	30%*	50%	30%*	50%	30%*	50%
Emergency/Urgent Care and Ambulance Services						
Emergency services	\$250	\$250	\$250	\$250	\$250	\$250
Urgent care services	\$35/visit✓	50%	\$35/visit✓	50%	\$35/visit✓	50%
Emergency medical transportation	30%	30%	30%	30%	30%	30%
OTHER COVERED SERVICES						
X-ray and lab services	30%**	50%	30%**	50%	30%**	50%
Outpatient rehabilitative services (30 visits per calendar year)	30%	50%	30%	50%	30%	50%
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	30%	50%	30%	50%	30%	50%

✓ No deductible needs to be met prior to receiving this benefit. *Deductible does not apply to diabetes supplies. ** Deductible is waived for first \$500 of in-plan services per calendar year.

This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).

2012 Medical plan comparison (cont.)

	Plan 15 (HSA) 20/40/\$5,500 \$1,500cd	
	In plan	Out of plan
Calendar Year Medical/Pharmacy Deductible	\$1,500/\$3,000	
Calendar Year Medical/Pharmacy out of pocket maximum	\$5,500/\$11,000 (includes deductible)	
Lifetime maximum benefit	unlimited	
	You pay	
WOMEN'S HEALTH CARE SERVICES		
Gynecological exams(calendar year Pap tests)	Covered in full✓	40%
Mammograms	Covered in full✓	40%
PHYSICIAN/PROVIDER SERVICES		
Office visits	20%	40%
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	40%
Inpatient hospital visits	20%	40%
Allergy shots, serums and injectable medications	20%	40%
Routine immunizations/shots	Covered in full✓	40%
HOSPITAL SERVICES		
Inpatient care	20%	40%
MATERNITY SERVICES		
Prenatal and postnatal visits; delivery	20%	40%
Hospital services	20%	40%
Routine newborn nursery care	20%	40%
DURABLE MEDICAL EQUIPMENT		
Medical, diabetes supplies, appliances and prosthetics	20%	40%
Emergency/Urgent Care and Ambulance Services		
Emergency services	20%	40%
Urgent care services	20%	40%
Emergency medical transportation	20%	20%
OTHER COVERED SERVICES		
X-ray and lab services	20%	40%
Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	20%	40%
Office visits to alternative care providers (any licensed provider; limited to \$500 per calendar year)	20%	20%
Prescription Drugs (30 day supply)	20%	Not covered

✓ No deductible needs to be met prior to receiving this benefit.

2012 Prescription drug, alternative care and vision plan benefits

Prescription drug benefits - Medical plan deductible does not apply, does not apply to the medical out-of-pocket maximums.
(provided for Plans 3, 5, 5 Plus, 7, 10, 25, Value Plan 5, Value Plan 7 and Value Plan 10)

You pay	
RETAIL PHARMACY (30-DAY SUPPLY)	
Generic	\$15
Brand	\$45
MAIL-ORDER PHARMACY (90- DAY SUPPLY OF MAINTENANCE DRUGS)	
Generic	\$45
Brand	\$135

* If you or your physician request a brand-name drug when a generic is available, you will be responsible for paying the cost difference, in addition to your brand-name drug copay.

Prescription drug benefits (provided for Plan 15 HSA)

Calendar year medical/pharmacy deductible (individual/family)	\$1,500/\$3,500
Calendar year medical/pharmacy out-of-pocket maximum(individual/family)	\$5,500/\$11,000
RETAIL PHARMACY (30-DAY SUPPLY)	
Generic	20%
Brand	20%
MAIL-ORDER PHARMACY (90- DAY SUPPLY OF MAINTENANCE DRUGS)	
Generic	20%
Brand	20%

Alternative care benefits - Medical plan deductible does not apply, does not apply to the medical out-of-pocket maximums.
(provided for Plans 3, 5, 5 Plus, 7, 10)

Providers	Participating chiropractor, naturopath or acupuncturist only
Copay	\$15
Benefit limit per calendar year	\$1,500 per member

Vision benefits - Medical plan deductible does not apply, does not apply to the medical out-of-pocket maximums.

Providers	Licensed eye care providers
Benefit limit	Up to \$300 per calendar year
Covered services	Vision exams, prescription lenses, frames, prescription contact lenses