EAST VALLEY SCHOOL DISTRICT
2009-2010 Rates and Benefits

THIS IS NOT A CONTRACT. For a more detailed description of your benefits and exclusions, refer to the plan documents or contact your employer or benefits administrator.

RATES	GROUP HEALTH COOPERATIVE PLAN 1	PREMERA BLUE CROSS PLAN 1 Heritage Network	PREMERA BLUE CROSS PLAN 2 Heritage Network	PREMERA BLUE CROSS PLAN 3 Heritage Network	PREMERA BLUE CROSS EasyChoice A Heritage Network	PREMERA BLUE CROSS EasyChoice B Heritage Network	PREMERA BLUE CROSS EasyChoice C Foundation Network	PREMERA BLUE CROSS Plan 5 Foundation Network
Employee	$560.09	$635.35	$555.95	$497.35	$403.85			$570.00
Employee & Spouse	$1,086.58	$1,234.10	$1,076.55	$963.30	$781.85			$1,156.00
Employee & Child(ren)	$784.13	$888.85	$776.50	$694.80	$563.95			$812.45
Employee & Family	$1,310.62	$1,487.60	$1,297.10	$1,160.75	$941.95			$1,398.45
DEDUCTIBLE	None	$50 per person/$150 per family; no deductible for office visits, preventive care or prescription drugs	$100 per person $300 per family; no deductible for office visits, preventive care or prescription drugs	$200 per person $600 per family; no deductible for office visits, preventive care or prescription drugs	$1,000 per person $3,000 per family: no deductible for office visits, preventive care or generic prescriptions	$750 per person $2,250 per family: no deductible for office visits, preventive care or generic prescriptions	No Deductible	$100 per person $300 per family; no deductible for office visits, preventive care or prescription drugs
OFFICE VISIT	$15 copay	$20 copay	$25 copay	$30 copay	$15 copay	$30 copay	$35 copay	$15 copay
PRESCRIPTION DRUGS *Home delivery available at cost savings*	$10 generic $20 brand name $40 Non-Formulary	$10 generic $15 brand name $30 non-preferred	$10 generic $20 brand name $35 non-preferred	$15 generic $25 brand name $40 non-preferred	Plan Deductible waived for Generics $500 Ded. PCY $0 generic 30% brand name 30% non-preferred	$250 Ded. PCY $0 generic $30 brand name $45 non-preferred	$500 Ded. PCY $0 generic $30 brand name $45 non-preferred	$10 generic $15 brand name $30 non-preferred
HOSPITALIZATION	$100 copay per day up to 3 days per admission	$100 copay per day to $300 max. PCY; 90% to $4,000 in Premera payments; then paid in full	$150 copay per day to $450 max. PCY; 80% to $5,500 in Premera payments; then paid in full	$300 copay per day to $900 max. PCY; 80% to $10,000 in Premera payments; then paid in full	Deductible & 20% Coinsurance	Deductible & 25% Coinsurance	Deductible & 35% Coinsurance	$200 per admission $600 max. copay per calendar year; then covered in full
LAB & RADIOLOGY	Covered in full	90% to $4,000 in Premera payments; then paid in full	80% to $5,500 in Premera payments; then paid in full	80% to $10,000 in Premera payments; then paid in full	1st $1,000 paid in full; then Plan Deductible & 20% Coinsurance	Deductible & 25% Coinsurance	Deductible & 35% Coinsurance	Covered in full
OUTPATIENT SURGERY	$15 copay	$50 copay; 90% to $4,000 in Premera payments; then paid in full	$100 copay; 80% to $5,500 in Premera payments; then paid in full	$150 copay; 80% to $10,000 in Premera payments; then paid in full	Deductible & 20% Coinsurance	Deductible & 25% Coinsurance	Deductible & 35% Coinsurance	Covered in full
EMERGENCY ROOM	$100 copay	$75 copay; 90% to $4,000 in Premera payments; then paid in full	$75 copay; 80% to $5,500 in Premera payments; then paid in full	$100 copay; 80% to $10,000 in Premera payments; then paid in full	$100 copay; Plan Deductible & 20% Coinsurance	$150 copay; Plan Deductible & 25% Coinsurance	$200 copay; Plan Deductible & 35% Coinsurance	$50 copay; then covered in full

Source: 2009 Premera Blue Cross Benefits Booklet & WEA 2009-10 Renewal Summary Memo
Coverage provided by Group Health Cooperative: CREATED BY GROUP HEALTH COOPERATIVE
* Note: All Premera health plans have out-of-network benefits. See coverage summary for more details.
2009 CW Grid (3) – GH Plan 1