

WBBA Benefit Program – 2010

Underwritten by Premera Blue Cross

Plan D (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network		
Office Visit Copay	\$20 Copay In-Network	
Deductible (Shared In and Out of Network)	\$300 (x 3 for family)	
Out-of-Pocket Maximum per calendar year (PCY) (Family x 3) shared in and out-of-network	\$1,800 (Includes deductibles; excludes copays)	
Coinsurance	In-Network: 20% *	Out-of-Network: 50% *
COVERED SERVICES **	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE ***		
Preventive Care Office Visit (Unlimited)	Subject to Office Visit Copay	Not Covered
Immunizations	Covered in full	
Health Education, Community Wellness & Diabetes Education (HE and CW shared \$250 maximum)	Covered in full	
Smoking Cessation (up to \$500 PCY)	Covered in full	
PROFESSIONAL CARE		
Office Visit (Includes 1 vision & hearing exam PCY)	Subject to Office Visit Copay	Deductible, then Coinsurance
Other Outpatient Professional Services	20%	
Inpatient Professional Services	20%	
Diagnostic Imaging & Laboratory Services	20%	
Mammography	20%	
FACILITY CARE		
Inpatient Care	20%	Deductible, then Coinsurance
Skilled Nursing Facility (up to 60 days PCY)	20%	
Outpatient Surgery	20%	
EMERGENCY CARE		
Outpatient Emergency Care (Copay waived if direct admit to an inpatient facility)	\$200 Copay, then Deductible/ 20% Benefits are provided at the In-Network level regardless of provider status, if the provider is out-of-network the provider may balance bill.	
Ambulance Transportation	20%	
Urgent Care	Subject to Office Visit Copay	Deductible, then Coinsurance
OTHER SERVICES		
Transplants (6 month waiting period; \$350,000 lifetime max)	Outpatient: Subject to Office Visit Copay Inpatient Care & Outpatient Surgery: 20%	Not Covered
Chemical Dependency Treatment - unlimited	Outpatient: Subject to Office Visit Copay; Inpatient: 20%	Deductible, then Coinsurance
Mental Health Care - unlimited	Outpatient: Subject to Office Visit Copay; Inpatient: 20%	
Hospice Care (6 months maximum; Inpatient: 10 days maximum; Respite: 240 hrs maximum)	20%	
Home Health Care (130 home health agency visits PCY)	20%	
Medical Supplies, Prosthetics \$10,000 PCY Orthotics \$300	20%	
Spinal and Other Manipulations (12 visits PCY)	Subject to Office Visit Copay	
Acupuncture (12 visits PCY)	Subject to Office Visit Copay	
Naturopathic Services	Subject to Office Visit Copay	
Contraceptive Management (Includes voluntary sterilization)	20%/ OV copay if office visit	
Rehabilitation (Including PT, OT, ST, Cardiac & Pulmonary Rehab and Massage Therapy) Outpatient: 45 visits PCY; Inpatient: 30 days PCY	Outpatient: Subject to Office Visit Copay; Inpatient: 20%	
Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime	Outpatient: Subject to Office Visit Copay; Inpatient: 20%	
LIFETIME MAXIMUM	\$2 Million	

PCY = per calendar year. *Reflects allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross.

Benefits listed apply after calendar year deductible is met, unless otherwise specified. *Deductible waived

pharmacy benefits

OUTPATIENT PRESCRIPTION DRUGS	Cost Share Options Generic/Preferred Brand/Non-Preferred Brand
Retail Pharmacy Copays Up to 30 day supply per Rx	\$10/\$25/\$50
Mail Service Copays Up to 90 day supply per Rx	\$20/\$50/\$100
Deductible	None
Out-of-Network Nonparticipating retail and mail pharmacies	Applicable Copay, then 40% Cost Share

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.