

WBBA Benefit Program - 2009

Underwritten by Premera Blue Cross

WBBA – Plan H HSA 1700 (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network		
NETWORK Heritage Plus 1	COST SHARES REPRESENT WHAT YOU PAY	
Individual Deductible/ Aggregate Family Deductible Per calendar year.	\$1,700/\$3,400	
Out of Pocket Maximum Out of Pocket Maximum is per calendar year (includes deductibles)	\$4,200 Individual/ \$8,400 Family	
Coinsurance† In-Network / Out-of-Network after Deductible	20%	50%
COVERED SERVICES *	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE	Unlimited	
Preventive Care Office Visit	20% (deductible waived)	
Immunizations		
Diabetes Education		
PROFESSIONAL CARE/DIAGNOSTIC SERVICES		
Office Visit	20%	
Other Outpatient Professional Services		
Inpatient Professional Services		
Diagnostic Imaging and Laboratory Services		
Mammography	50%	
FACILITY CARE		
Inpatient Care		
Skilled Nursing Facility 60 days Per Calendar Year		
Outpatient Surgery Facility	20%	
EMERGENCY CARE		
Urgent Care		
Outpatient Emergency Care	20%	
Ambulance Transportation	Benefits are provided at the In-Network level regardless of provider status, if the provider is out-of-network the provider may balance bill.	
OTHER SERVICES		
Transplants (Outpatient: Office Visit Copay or Coinsurance applies) 6-month waiting period / \$250,000 lifetime benefit max	20%	Not Covered
Mental Health Care (Inpatient: 10 Days PCY; Outpatient: 20 Visits PCY)	20%	50%
Chemical Dependency Treatment \$14,500 max per 24-month period	20%	
Rehabilitation (Inpatient: 30 Days PCY; Outpatient: 15 Visits PCY)		
Neurodevelopmental Therapy Inpatient: 30 Days PCY; Outpatient: 15 Visits PCY		
Hospice Care 6-month maximum		
Home Health Care 130 visits PCY		
Spinal and Other Manipulations 12 visits PCY		
Acupuncture 12 visits PCY		
Naturopathic Services		
Temporomandibular Joint (TMJ) Disorders	Not Covered	Not Covered
PRESCRIPTION Rx (subject to medical deductible)		
Retail 30 day retail	20%	20%
Mail Order Up to 90 Day Mail Order	20%	20%
LIFETIME BENEFIT MAXIMUM	\$2,000,000	

PCY = Per Calendar Year. † All coinsurance amounts are based on a percentage of allowable charges after the deductible is met. You may be responsible for additional charges if a provider is not contracted with Premera Blue Cross. *Benefits listed apply after calendar year deductible is met, unless otherwise specified.

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Plan Year 2009