

WBBA Benefit Program – 2009

Underwritten by Premera Blue Cross

Plan D (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network		
Deductible (Shared In and Out of Network)	\$300 (x 3 for family)	
Office Visit Copay ***	\$20 In-Network	
Out-of-Pocket Maximum per calendar year (PCY) (Family x 3) shared in and out-of-network	\$1,300 (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 then 20%	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/20%	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)	\$150 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 then 20%	Deductible, then Coinsurance
OTHER SERVICES		
Transplants (6 month waiting period; \$250,000 lifetime max)	Outpatient: Subject to Office Visit Copay + 20% Inpatient Care & Outpatient Surgery: 20%	Not Covered
Chemical Dependency Treatment (\$14,500 max per 24 mo.)	Outpatient: Subject to Office Visit Copay + 20%; Inpatient: 20%	Deductible, then Coinsurance
Mental Health Care (Outpatient: 20 visits PCY; Inpatient: 10 days PCY)	Outpatient: Subject to Office Visit Copay + 20%; 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 +20%	
Acupuncture (12 visits PCY)	Subject to Office Visit Copay +20%	
Naturopathic Services	Subject to Office Visit Copay +20%	
Contraceptive Management (Includes voluntary sterilization)	20%/ OV copay if office visit +20%	
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 +20%; Inpatient: 20%	
Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime	Outpatient: Subject to Office Visit Copay+ 20%; 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/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.