

WBBA Benefit Program - 2009

Underwritten by Premera Blue Cross

| Plan C (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network | | |
|--|---|------------------------------|
| Office Visit Copay | \$20 In-Network | |
| Deductible (Shared In and Out of Network) | \$200 (x 3 for family) | |
| Out-of-Pocket Maximum per calendar year (PCY) (Family x 3) shared in and out-of-network | \$2,700 (Includes deductibles; excludes copays) | |
| Coinsurance | IN-NETWORK: 10% * | 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 | 10% | |
| Inpatient Professional Services | 10% | |
| Diagnostic Imaging & Laboratory Services | 10% | |
| Mammography | 10% | |
| FACILITY CARE | | |
| Inpatient Care | 10% | Deductible, then Coinsurance |
| Skilled Nursing Facility (up to 60 days PCY) | 10% | |
| Outpatient Surgery | 10% | |
| EMERGENCY CARE | | |
| Outpatient Emergency Care (Copay waived if direct admit to an inpatient facility) | \$150 Copay, then Deductible / 10% 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 | 10% | |
| Urgent Care | Subject to Office Visit Copay | Deductible, then Coinsurance |
| OTHER SERVICES | | |
| Transplants (6 month waiting period; \$250,000 lifetime max) | Outpatient: Subject to Office Visit Copay; Inpatient Care & Outpatient Surgery: 10% | Not Covered |
| Chemical Dependency Treatment (\$14,500 max per 24 mo.) | Outpatient: Subject to Office Visit Copay; Inpatient: 10% | Deductible, then Coinsurance |
| Mental Health Care (Outpatient: 20 visits PCY; Inpatient: 10 days PCY) | Outpatient: Subject to Office Visit Copay; Inpatient: 10% | |
| Hospice Care (6 months maximum; Inpatient: 10 days maximum; Respite: 240 hrs maximum) | 10% | |
| Home Health Care (130 home health agency visits PCY) | 10% | |
| Medical Supplies, Prosthetics \$10,000 PCY Orthotics \$300 | 10% | |
| Spinal and Other Manipulations (24 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) | 10%/ 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: 10% | |
| Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime | Outpatient: Subject to Office Visit Copay; Inpatient: 10% | |
| 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 for Preventive Care.

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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.