



WBBA Benefit Program - 2009
Underwritten by Premera Blue Cross

Plan G HRA (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network		
Deductible (Shared In and Out of Network)	\$1000 (x 3 for family)	
Out-of-Pocket Maximum per calendar year (PCY) (Family x 3) shared in and out-of-network	\$3,500 (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)	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	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 90 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%	
Ambulance Transportation	20%	
Urgent Care	20%	Deductible, then coinsurance
OTHER SERVICES		
Transplants (6 month waiting period; \$250,000 lifetime max)	20%	Not Covered
Chemical Dependency Treatment (\$14,500 max per 24 mo.)	20%	Deductible, then coinsurance
Mental Health Care (Outpatient: 20 visits PCY; Inpatient: 10 days PCY)	20%	
Hospice Care (6 months max; Inpatient: 10 days max; Respite: 240 hrs max)	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)	20%	
Acupuncture (12 visits PCY)	20%	
Naturopathic Services	20%	
Contraceptive Management (Includes voluntary sterilization)	20%	
Rehabilitation (Including PT, OT, ST, Cardiac & Pulmonary Rehab and Massage Therapy) Outpatient: 45 visits PCY; Inpatient: 30 days PCY	20%	
Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime	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



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Plan Year 2009

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pharmacy benefits

OUTPATIENT PRESCRIPTION DRUGS	Cost Share Options Tier 1/Tier 2 Preferred Brand/ Tier 3 Non-Preferred Brand
Retail Pharmacy Copays Up to 30 day supply per Rx	\$10/\$30/\$60
Mail Service Copays Up to 90 day supply per Rx	\$20/\$60/\$120
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.