



**WBBA Benefit Program – 2009**  
Underwritten by Premera Blue Cross

<b>Plan B</b> (Note: Copays, deductibles, and coinsurance percentages reflect <b>member's</b> cost share) Heritage Network		
<b>Office Visit Copay</b>	\$15 In-Network	
<b>Deductible (Shared In and Out of Network)</b>	\$150 (x 3 for family)	
<b>Out-of-Pocket Maximum</b> per calendar year (PCY) (Family x 3) shared in and out-of-network	\$2,650 (Includes deductibles; excludes copays)	
<b>Coinsurance</b>	IN-NETWORK: 0% *	OUT-OF-NETWORK: 50% *
<b>COVERED SERVICES **</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>PREVENTIVE CARE ***</b>		
<b>Preventive Care Office Visit</b> (Unlimited)	Subject to Office Visit Copay	Not Covered
<b>Immunizations</b>	Covered in full	
<b>Health Education, Community Wellness &amp; Diabetes Education (HE and CW shared \$250 maximum)</b>	Covered in full	
<b>Smoking Cessation</b> (up to \$500 PCY)	Covered in full	
<b>PROFESSIONAL CARE</b>		
<b>Office Visit</b> (Includes 1 vision & hearing exam PCY)	Subject to Office Visit Copay	Deductible, then Coinsurance
<b>Other Outpatient Professional Services</b>	0%	
<b>Inpatient Professional Services</b>	0%	
<b>Diagnostic Imaging &amp; Laboratory Services</b>	0%	
<b>Mammography</b>	0%	
<b>FACILITY CARE</b>		
<b>Inpatient Care</b>	0%	Deductible, then Coinsurance
<b>Skilled Nursing Facility</b> (up to 60 days PCY)	0%	
<b>Outpatient Surgery</b>	0%	
<b>EMERGENCY CARE</b>		
<b>Outpatient Emergency Care</b> (Copay waived if direct admit to an inpatient facility)	\$150 Copay, then Deductible / 0% Benefits are provided at the In-Network level regardless of provider status, if the provider is out-of-network the provider may balance bill.	
<b>Ambulance Transportation</b>	0%	
<b>Urgent Care</b>	Subject to Office Visit Copay	Deductible, then Coinsurance
<b>OTHER SERVICES</b>		
<b>Transplants</b> (6 month waiting period; \$250,000 lifetime max)	Outpatient: Subject to Office Visit Copay ; Inpatient Care & Outpatient Surgery: 0%	Not Covered
<b>Chemical Dependency Treatment</b> (\$14,500 max per 24 mo.)	Outpatient: Subject to Office Visit Copay; Inpatient: 0%	Deductible, then Coinsurance
<b>Mental Health Care</b> (Outpatient: 20 visits PCY; Inpatient: 10 days PCY)	Outpatient: Subject to Office Visit Copay; Inpatient: 0%	
<b>Hospice Care</b> (6 months maximum; Inpatient: 10 days maximum; Respite: 240 hrs maximum)	0%	
<b>Home Health Care</b> (130 home health agency visits PCY)	0%	
<b>Medical Supplies, Prosthetics \$10,000 PCY Orthotics \$300</b>	0%	
<b>Spinal and Other Manipulations</b> ( 24 visits PCY)	Subject to Office Visit Copay	
<b>Acupuncture</b> (12 visits PCY)	Subject to Office Visit Copay	
<b>Naturopathic Services</b>	Subject to Office Visit Copay	
<b>Contraceptive Management</b> (Includes voluntary sterilization)	0%/ OV copay if office visit	
<b>Rehabilitation</b> (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: 0%	
<b>Temporomandibular Joint (TMJ) Disorders</b> \$1,000 PCY; \$5,000 Lifetime	Outpatient: Subject to Office Visit Copay; Inpatient: 0%	
<b>LIFETIME MAXIMUM</b>	\$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.



An Independent Licensee of the  
Blue Cross Blue Shield Association  
Plan Year 2009

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## pharmacy benefits

OUTPATIENT PRESCRIPTION DRUGS	Cost Share Options Generic/Brand
<b>Retail Pharmacy Copays</b> Up to 30 day supply per Rx	\$10/\$25/\$50
<b>Mail Service Copays</b> Up to 90 day supply per Rx	\$20/\$50/\$100
<b>Deductible</b>	None
<b>Out-of-Network</b> 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.