



WBBA Benefit Program - 2009

Underwritten by Premera Blue Cross

WBBA – Plan E (Note: Copays, deductibles, and coinsurance percentages reflect member's cost share) Heritage Network		
Deductible (Shared In and Out of Network)	\$500 (x 3 for family)	
Office Visit Copay †	\$25 In-Network	
Out-of-Pocket Maximum per calendar year (PCY) (Family x 3) shared in and out-of-network	\$3,000 (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)	4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 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	4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible, then Coinsurance
Other Outpatient Professional Services	20%	
Inpatient Professional Services	20%	
Diagnostic Imaging & Laboratory Services (\$500 limit shared with Pap/PSA limit)	Covered in Full to \$500; then Deductible Plus 20%	
Pap Smears and PSA Testing	Covered in Full to \$500; then 20% (Deductible Waived)	
Mammography	1 PCY in full; then 20% (Deductible Waived)	
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% 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	4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible, then Coinsurance
OTHER SERVICES		
Transplants (6 month waiting period; \$250,000 lifetime max)	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Not Covered
Chemical Dependency Treatment (\$14,500 max per 24 mo.)	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible, then Coinsurance
Mental Health Care (Outpatient: 20 visits PCY; Inpatient: 10 days PCY)	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 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)	\$25 OV Copay***	



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Plan Year 2009



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Acupuncture (12 visits PCY)	\$25 OV Copay***	
Naturopathic Services	4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible and Coinsurance
Contraceptive Management (voluntary sterilization falls under Ded./Coins.)	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible and Coinsurance
Rehabilitation (Including PT, OT, ST, Cardiac & Pulmonary Rehab and Massage Therapy) Outpatient: 45 visits PCY; Inpatient: 30 days PCY	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 20%	Deductible and Coinsurance
Temporomandibular Joint (TMJ) Disorders \$1,000 PCY; \$5,000 Lifetime	Inpatient:20%; Outpatient: 4 Visits at \$25 Copay***, then \$25 Copay, Deductible and 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

†The four-visit limit is a combined total of all specified in-network visits

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.

