

Premera Blue Cross WEA Select Health Plans

All benefit changes effective October 1, 2009

(PCY=Per Calendar Year)

PLAN 1—HERITAGE NETWORK

Copayments, coinsurance and deductible amounts represent what **you pay** • All benefits subject to deductible unless otherwise noted

YOUR COST SHARES		In-Network	Out-of-Network	
Office Visit Cost Shares		\$20*	\$25*	
Deductible Per Calendar Year (PCY)	INDIVIDUAL	\$50	Combined with In-Network deductible	
	FAMILY	\$150	Combined with In-Network deductible	
Coinsurance		10%	30%	
Out-of-Pocket Maximum PCY**	INDIVIDUAL	\$444	\$1,714	
	FAMILY		N/A	
YOUR COVERED SERVICES		In-Network	Out-of-Network	
PREVENTIVE CARE				
Exams/Immunizations		\$0*	20%*	
	LIMITS	Up to \$300 per person PCY or \$600 per person PCY through age 3, shared with Preventive Screenings		
Preventive Screenings		\$0*	20%*	
	LIMITS	Up to \$300 per person PCY or \$600 per person PCY through age 3, shared with Exams/Immunizations		
Mammography (preventive)		See DIAGNOSTIC SERVICES		
PROFESSIONAL CARE				
Medical Office Visit, Naturopathic Office Visit		\$20*	\$25*	
	LIMITS	Unlimited		
Chiropractic Manipulations (spinal & other)		\$20*	\$25*	
	LIMITS	Unlimited		
Acupuncture		\$20*	\$25*	
	LIMITS	12 visits PCY		
DIAGNOSTIC SERVICES				
Diagnostic Imaging/Laboratory		Deductible + Coinsurance		
Mammography (diagnostic)		Deductible + Coinsurance		
Colon Health Screenings		Outpatient Surgery Copay + Deductible + Coinsurance		
MATERNITY				
Prenatal/Postnatal Care		Deductible + Coinsurance		
Delivery		See HOSPITAL/FACILITY CARE		
HOSPITAL/FACILITY CARE				
Inpatient		Inpatient Copay + Deductible + Coinsurance		
Inpatient Copay	INDIVIDUAL	\$100 per day, \$300 Max PCY		
	FAMILY	N/A		
Outpatient Hospital/Facility		Deductible + Coinsurance		
Outpatient Surgery Copay		\$50		
EMERGENCY CARE				
Professional / Facility		Deductible + Coinsurance		
ER Copay (waived if admitted)		\$75		
Ambulance		Deductible + Coinsurance		
OTHER SERVICES				
Mental Health Outpatient		\$20*	\$25*	
	LIMITS	50 visits PCY		
Mental Health Inpatient		Inpatient Copay + Deductible + Coinsurance		
	LIMITS	Unlimited		
Rehabilitation Outpatient (PT, Massage, Speech, OT)		\$20*	\$25*	
	LIMITS	45 visits PCY; Physical therapy (PT) unlimited, deductible + coinsurance		
Rehabilitation Inpatient		Inpatient Copay + Deductible + Coinsurance		
	LIMITS	120 days PCY		
PRESCRIPTION DRUGS (at participating pharmacies)		Generic	Preferred Brand Name	Non-preferred Brand Name
RX Deductible (waived for generics)		None		
RX Out-of-Pocket Maximum		N/A		
Retail Cost Share		\$10	\$15	\$30
	LIMITS	34 day supply		
Mail Order Cost Share		\$10	\$15	\$30
	LIMITS	100 day supply		
Specialty Drug Cost Share		Subject to applicable retail copay		
	LIMITS	30 day supply		
Lifetime Maximum		\$5 million—revolving each five years		
Unum (Life & AD&D insurance)†		\$20,000 decreasing term life and AD&D for employee only		

* Not subject to the calendar year deductible

** Out-of-pocket maximum includes coinsurance only. Covered in-network services paid at 100% of allowable charges for remainder of calendar year once out-of-pocket maximum is met. Out-of-network paid on same basis.

† Unum is an independent provider of life insurance services that does not provide Premera Blue Cross products or services. Unum is solely responsible for its products and services.

NOTE: This summary is intended to assist you in decision making. Details of covered benefits, limitations, and exclusions are provided in the WEA Select Health Plan benefit booklets. This summary of benefits is not a contract.