WEA Select Current Plans • October 1, 2009

KEY FEATURES FOR IN-NETWORK SERVICES

Rates vary by plan to meet different needs

No deductible for office visits, preventive care and prescription drugs

Preventive care and immunizations unlimited for *(FOUNDATION)* / PLAN 5

(FOUNDATION) / **PLAN 5**

- Foundation provider network
- $15 office visit copayment and 0% coinsurance level
- $100 calendar year deductible
- Lowest out-of-pocket maximum

PLAN 1

- Heritage provider network
- $20 office visit copayment and10% coinsurance level
- $50 calendar year deductible
- Low out-of-pocket maximum

PLAN 2

- Heritage provider network
- $25 office visit copayment and 20% coinsurance level
- $100 calendar year deductible
- Moderate out-of-pocket maximum

PLAN 3

- Heritage provider network
- $30 office visit copayment and 20% coinsurance level
- $200 calendar year deductible
- Higher out-of-pocket maximum

Need more details?

Go to **www.premera.com/wea** or
call the WEA Select Service Team:
Toll Free **1-800-932-9221**
Toll Free Hearing Impaired TDD **1-800-842-5357**

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		(FOUNDATION) / **PLAN 5**	**PLAN 1**	**PLAN 2**	**PLAN 3**
Provider Network		Foundation	Heritage	Heritage	Heritage

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		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
Deductible Per Calendar Year (PCY)	INDIVIDUAL	$100 / $250	$50 / Combined with In-Network deductible	$100 / Combined with In-Network deductible	$200 / Combined with In-Network deductible
	FAMILY	$300 / $250 per family member	$150 / Combined with In-Network deductible	$300 / Combined with In-Network deductible	$600 / Combined with In-Network deductible
Coinsurance		0% / 30%	10% / 30%	20% / 40%	20% / 40%
Out-of-Pocket Maximum PCY**	INDIVIDUAL	$0 / No out-of-pocket maximum	$444 / $1,714	$1,375 / $3,667	$2,500 / $6,667
	FAMILY	N/A			

YOUR COVERED SERVICES		In-Network / Out-of-Network			
PREVENTIVE CARE					
Exams/Immunizations		$15* / Not covered	$0* / 20%*	$0* / 20%*	$0* / 20%*
	LIMITS	Unlimited	Up to $300 per person PCY or $600 per person PCY through age 3, shared with Preventive Screenings		
Preventive Screenings		$0* / 30%	$0* / 20%*	$0* / 20%*	$0* / 20%*
	LIMITS	Unlimited	Up to $300 per person PCY or $600 per person PCY through age 3, shared with Exams/Immunizations		
Mammography (preventive)		$0* / 30%	See DIAGNOSTIC SERVICES		
PROFESSIONAL CARE					
Medical Office Visit, Naturopathic Office Visit		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
	LIMITS	Unlimited			
Chiropractic Manipulations (spinal & other)		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
	LIMITS	Unlimited			
Acupuncture		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
	LIMITS	Unlimited	12 visits PCY		
DIAGNOSTIC SERVICES					
Diagnostic Imaging/Laboratory		Deductible + Coinsurance			
Mammography (diagnostic)		Deductible + Coinsurance			
Colon Health Screenings		Outpatient Surgery Copay (Plans 1, 2 & 3) + Deductible + Coinsurance			
MATERNITY					
Prenatal/Postnatal Care		Deductible + Coinsurance			
Delivery		See HOSPITAL/FACILITY CARE			
HOSPITAL/FACILITY CARE					
Inpatient		Inpatient Copay + Deductible + Coinsurance			
Inpatient Copay	INDIVIDUAL	$200 per admission, $600 Max PCY	$100 per day, $300 Max PCY	$150 per day, $450 Max PCY	$300 per day, $900 Max PCY
	FAMILY	$1,000 PCY	N/A		
Outpatient Hospital/Facility		Deductible + Coinsurance			
Outpatient Surgery Copay		None	$50	$100	$150
EMERGENCY CARE					
Professional / Facility		Deductible + Coinsurance			
ER Copay (waived if admitted)		$50	$75		$100
Ambulance		$50	Deductible + Coinsurance		
OTHER SERVICES					
Mental Health Outpatient		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
	LIMITS	20 visits PCY	50 visits PCY		30 visits PCY
Mental Health Inpatient		Inpatient Copay + Deductible + Coinsurance			
	LIMITS	30 days PCY	Unlimited		30 days PCY
Rehabilitation Outpatient (PT, Massage, Speech, OT)		$15* / 30%	$20* / $25*	$25* / $30*	$30* / $40*
	LIMITS	45 visits PCY	45 visits PCY; Physical therapy (PT) unlimited, deductible + coinsurance		
Rehabilitation Inpatient		Inpatient Copay + Deductible + Coinsurance			
	LIMITS	30 days PCY	120 days PCY		30 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	$10 / $15 / $30	$10 / $20 / $35	$15 / $25 / $40
	LIMITS	30 day supply	34 day supply		
Mail Order Cost Share		$10 / $30 / $60	$10 / $15 / $30	$10 / $20 / $35	$15 / $25 / $40
	LIMITS	90 day supply	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 for Plans 1, 2, and 3. EasyChoice out-of-pocket maximum includes coinsurance and deductible. Covered in-network services paid at 100% of allowable charges for remainder of calendar year once out-of-pocket maximum is met. Plans 1, 2 & 3 pay out-of-network on same basis. No out-of-pocket maximum for *(Foundation)* / Plan 5 and EasyChoice Plan for out-of-network services. † 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.