

WEA Select EasyChoice Plan • October 1, 2009

KEY FEATURES FOR IN-NETWORK SERVICES

3 options—one easy rate

No deductible for office visits, preventive care and generic prescriptions

Preventive care and immunizations are paid in full

Generic drugs are covered in full



EASYCHOICE A

- Heritage provider network
- \$15 office visit copayment and 20% coinsurance level
- \$1,000 calendar year deductible
- First \$1,000 of diagnostic lab and x-ray are covered in full, not subject to deductible

EASYCHOICE B

- Heritage provider network
- \$30 office visit copayment and 25% coinsurance level
- \$750 calendar year deductible
- Lowest prescription drug deductible

EASYCHOICE C

- Foundation provider network
- \$35 office visit copayment and 35% coinsurance level
- No deductible for in-network services
- Colonoscopies covered in full
- Coverage for hearing exams and hardware

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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	EASYCHOICE A	EASYCHOICE B	EASYCHOICE C
Provider Network	Heritage	Heritage	Foundation
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* / 50%	\$30* / 50%	\$35* / 50%
Deductible Per Calendar Year (PCY)	INDIVIDUAL \$1,000 / \$2,000	\$750 / \$1,500	\$0 / \$250
	FAMILY \$3,000 / \$6,000	\$2,250 / \$4,500	\$0 / \$750
Coinsurance	20% / 50%	25% / 50%	35%* / 50%
Out-of-Pocket Maximum PCY**	INDIVIDUAL \$5,000 / No out-of-pocket maximum	\$4,000 / No out-of-pocket maximum	\$7,500 / No out-of-pocket maximum
	FAMILY \$15,000 / No out-of-pocket maximum	\$12,000 / No out-of-pocket maximum	\$22,500 / No out-of-pocket maximum
YOUR COVERED SERVICES	In-Network / Out-of-Network		
PREVENTIVE CARE			
Exams/Immunizations		\$0* / Not covered	
	LIMITS	Unlimited	
Preventive Screenings		\$0* / 50%	
	LIMITS	Unlimited	
Mammography (preventive)		\$0* / 50%	
PROFESSIONAL CARE			
Medical Office Visit, Naturopathic Office Visit	\$15* / 50%	\$30* / 50%	\$35* / 50%
	LIMITS	Unlimited	
Chiropractic Manipulations (spinal & other)	\$15* / 50%	\$30* / 50%	\$35* / 50%
	LIMITS	12 visits PCY	
Acupuncture	\$15* / 50%	\$30* / 50%	\$35* / 50%
	LIMITS	12 visits PCY	
DIAGNOSTIC SERVICES			
Diagnostic Imaging/Laboratory	1st \$1,000 paid in full; then Deductible, Coinsurance	Deductible + Coinsurance	
Mammography (diagnostic)		\$0* / 50%	
Colon Health Screenings		Deductible + Coinsurance	0%* / 50%
MATERNITY			
Prenatal/Postnatal Care		Deductible + Coinsurance	
Delivery		See HOSPITAL/FACILITY CARE	
HOSPITAL/FACILITY CARE			
Inpatient		Deductible + Coinsurance	
Inpatient Copay	INDIVIDUAL FAMILY	None N/A	
Outpatient Hospital/Facility		Deductible + Coinsurance	
Outpatient Surgery Copay		None	
EMERGENCY CARE			
Professional / Facility		Deductible + Coinsurance	
ER Copay (waived if admitted)	\$100	\$150	\$200
Ambulance		Deductible + Coinsurance	
OTHER SERVICES			
Mental Health Outpatient	\$15* / 50%	\$30* / 50%	\$35* / 50%
	LIMITS	20 visits PCY	
Mental Health Inpatient		Deductible + Coinsurance	
	LIMITS	14 days PCY	
Rehabilitation Outpatient (PT, Massage, Speech, OT)	\$15* / 50%	\$30* / 50%	\$35* / 50%
	LIMITS	30 visits PCY	45 visits PCY
Rehabilitation Inpatient		Deductible + Coinsurance	
	LIMITS	30 days PCY	45 days PCY
PRESCRIPTION DRUGS (at participating pharmacies)			
RX Deductible (waived for generics)	\$500 per person PCY	\$250 per person PCY	\$500 per person PCY
RX Out-of-Pocket Maximum	\$5,000 per person PCY (includes Rx Deductible + Copay + Coinsurance)		
Retail Cost Share	\$0 / 30% / 30%	\$0 / \$30 / \$45	
	LIMITS	30 day supply	
Mail Order Cost Share	\$0 / 25% / 25%	\$0 / \$75 / \$112	
	LIMITS	90 day supply	
Specialty Drug Cost Share		30%	
	LIMITS	30 day supply	
Lifetime Maximum	\$2 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.