

# Premera Blue Cross WEA Select Plan 1

All benefit changes effective October 1, 2011

Benefits that have changed are highlighted in gray    Ded + Coin = Deductible + Coinsurance    — Applies to in- and out-of-network —  
 IN = In-network    OUT = Out-of-network    PCY = Per Calendar Year    OT = Occupational therapy    PT = Physical therapy

## Heritage Provider Network

Copayments, Deductible & Coinsurance		IN	OUT
<b>Copayments</b>			
Office Visit		\$20*	\$25*
Inpatient Copay	Individual	\$100 per day, \$300 Max PCY	
	Family	N/A	
Outpatient Surgery Copay			\$50
ER Copay (waived if admitted)			\$75
<b>Deductible</b>			
Deductible PCY	Individual	\$50 combined IN + OUT	
	Family	\$150 combined IN + OUT	
<b>Coinsurance</b>			
Coinsurance		10%	30%
Out-of-Pocket Maximum PCY**	Individual	\$500 combined IN + OUT	
	Family	\$1,500 combined IN + OUT	
Covered Services		IN	OUT
<b>Office Visits – Professional Care</b>			
Medical and Naturopathic Office Visits	unlimited	\$20*	\$25*
Spinal and Other Manipulations	unlimited visits (chiropractic)	\$20*	\$25*
Acupuncture	12 visits PCY	\$20*	\$25*
<b>Preventive Care</b> unlimited			
Exams/Immunizations		\$0*	20%
Preventive Screenings	(includes mammography and colon health screenings)	Same as above	
<b>Diagnostic Services</b>			
Diagnostic Imaging/Laboratory		Ded + Coin	
<b>Hospital/Facility Care</b>			
Outpatient		Outpatient Surgery Copay + Ded + Coin	
Inpatient		Inpatient Copay + Ded + Coin	
Maternity – Prenatal/Postnatal Care		Ded + Coin	
Maternity – Delivery		See Outpatient or Inpatient Hospital/Facility Care	
<b>Emergency Care</b>			
Professional/Facility		ER Copay + Ded + Coin	
Ambulance	(air and ground)	Ded + Coin	
Mental Health Outpatient	unlimited visits	\$20*	\$25*
Mental Health Inpatient	unlimited days	Inpatient Copay + Ded + Coin	
Rehabilitation Outpatient	45 visits PCY (PT, Massage, Speech, OT) (PT unlimited)	\$20*	\$25*
		PT Ded + Coin	
Rehabilitation Inpatient	120 days PCY	Inpatient Copay + Ded + Coin	
Prescription Drugs (participating pharmacies)		Generic / Preferred Brand Name / Non-preferred Brand Name	
Rx Deductible	per person PCY	None	
Rx Out-of-Pocket Maximum	per person PCY	N/A	
Retail Cost Share	34 day supply	\$10 / \$15 / \$30	
Mail Order Cost Share	100 day supply	\$10 / \$15 / \$30	
Specialty Drug Cost Share	30 day supply	Subject to applicable retail copay	
<b>Unum</b> (Life & AD&D insurance)†		\$12,500 Term Life and AD&D for employee only	

\* Not subject to the calendar year deductible

\*\* Out-of-pocket maximums include 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. 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.

# Premera Blue Cross WEA Select Plan 2

All benefit changes effective October 1, 2011

Benefits that have changed are highlighted in gray    Ded + Coin = Deductible + Coinsurance    —Applies to in- and out-of-network—  
 IN = In-network    OUT = Out-of-network    PCY = Per Calendar Year    OT = Occupational therapy    PT = Physical therapy

## Heritage Provider Network

Copayments, Deductible & Coinsurance		IN	OUT
<b>Copayments</b>			
Office Visit		\$25*	\$30*
Inpatient Copay	Individual	\$150 per day, \$450 Max PCY	
	Family	N/A	
Outpatient Surgery Copay			\$100
ER Copay (waived if admitted)			\$75
<b>Deductible</b>			
Deductible PCY	Individual	\$100 combined IN + OUT	
	Family	\$300 combined IN + OUT	
<b>Coinsurance</b>			
Coinsurance		20%	40%
Out-of-Pocket Maximum PCY**	Individual	\$1,500 combined IN + OUT	
	Family	\$4,500 combined IN + OUT	
Covered Services		IN	OUT
<b>Office Visits – Professional Care</b>			
Medical and Naturopathic Office Visits	unlimited	\$25*	\$30*
Spinal and Other Manipulations	unlimited visits (chiropractic)	\$25*	\$30*
Acupuncture	12 visits PCY	\$25*	\$30*
<b>Preventive Care</b> unlimited			
Exams/Immunizations		\$0*	20%
Preventive Screenings	(includes mammography and colon health screenings)	Same as above	
<b>Diagnostic Services</b>			
Diagnostic Imaging/Laboratory		Ded + Coin	
<b>Hospital/Facility Care</b>			
Outpatient		Outpatient Surgery Copay + Ded + Coin	
Inpatient		Inpatient Copay + Ded + Coin	
Maternity – Prenatal/Postnatal Care		Ded + Coin	
Maternity – Delivery		See Outpatient or Inpatient Hospital/ Facility Care	
<b>Emergency Care</b>			
Professional / Facility		ER Copay + Ded + Coin	
Ambulance	(air and ground)	Ded + Coin	
Mental Health Outpatient	unlimited visits	\$25*	\$30*
Mental Health Inpatient	unlimited days	Inpatient Copay + Ded + Coin	
Rehabilitation Outpatient	45 visits PCY (PT, Massage, Speech, OT) (PT unlimited)	\$25*	\$30* PT Ded + Coin
Rehabilitation Inpatient	120 days PCY	Inpatient Copay + Ded + Coin	
Prescription Drugs (participating pharmacies)		Generic / Preferred Brand Name / Non-preferred Brand Name	
Rx Deductible	per person PCY	None	
Rx Out-of-Pocket Maximum	per person PCY	N/A	
Retail Cost Share	34 day supply	\$10 / \$20 / \$35	
Mail Order Cost Share	100 day supply	\$10 / \$20 / \$35	
Specialty Drug Cost Share	30 day supply	Subject to applicable retail copay	
<b>Unum</b> (Life & AD&D insurance) †		\$12,500 Term Life and AD&D for employee only	

\* Not subject to the calendar year deductible

\*\* Out-of-pocket maximums include 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. 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.

# Premera Blue Cross WEA Select Plan 3

All benefit changes effective October 1, 2011

Benefits that have changed are highlighted in gray    Ded + Coin = Deductible + Coinsurance    — Applies to in- and out-of-network —  
 IN = In-network    OUT = Out-of-network    PCY = Per Calendar Year    OT = Occupational therapy    PT = Physical therapy

## Heritage Provider Network

Copayments, Deductible & Coinsurance		IN	OUT
<b>Copayments</b>			
Office Visit		\$30*	\$40*
Inpatient Copay	Individual	\$300 per day, \$900 Max PCY	
	Family	N/A	
Outpatient Surgery Copay		\$150	
ER Copay (waived if admitted)		\$100	
<b>Deductible</b>			
Deductible PCY	Individual	\$200 combined IN + OUT	
	Family	\$600 combined IN + OUT	
<b>Coinsurance</b>			
Coinsurance		20%	40%
Out-of-Pocket Maximum PCY**	Individual	\$2,750 combined IN + OUT	
	Family	\$8,250 combined IN + OUT	

Covered Services		IN	OUT
<b>Office Visits – Professional Care</b>			
Medical and Naturopathic Office Visits	unlimited	\$30*	\$40*
Spinal and Other Manipulations	unlimited visits (chiropractic)	\$30*	\$40*
Acupuncture	12 visits PCY	\$30*	\$40*
<b>Preventive Care</b> unlimited			
Exams/Immunizations		\$0*	20%
Preventive Screenings	(includes mammography and colon health screenings)	Same as above	
<b>Diagnostic Services</b>			
Diagnostic Imaging/Laboratory		Ded + Coin	
<b>Hospital/Facility Care</b>			
Outpatient		Outpatient Surgery Copay + Ded + Coin	
Inpatient		Inpatient Copay + Ded + Coin	
Maternity – Prenatal/Postnatal Care		Ded + Coin	
Maternity – Delivery		See Outpatient or Inpatient Hospital/Facility Care	
<b>Emergency Care</b>			
Professional/Facility		ER Copay + Ded + Coin	
Ambulance	(air and ground)	Ded + Coin	
Mental Health Outpatient	unlimited visits	\$30*	\$40*
Mental Health Inpatient	unlimited days	Inpatient Copay + Ded + Coin	
Rehabilitation Outpatient	45 visits PCY (PT, Massage, Speech, OT) (PT unlimited)	\$30*	\$40*
Rehabilitation Inpatient	30 days PCY	Inpatient Copay + Ded + Coin	

Prescription Drugs (participating pharmacies)	Generic / Preferred Brand Name / Non-preferred Brand Name
Rx Deductible per person PCY	None
Rx Out-of-Pocket Maximum per person PCY	N/A
Retail Cost Share 34 day supply	\$15 / \$25 / \$40
Mail Order Cost Share 100 day supply	\$15 / \$25 / \$40
Specialty Drug Cost Share 30 day supply	Subject to applicable retail copay

**Unum** (Life & AD&D insurance)†

\$12,500 Term Life and AD&D for employee only

\* Not subject to the calendar year deductible

\*\* Out-of-pocket maximums include 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. 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.

WEA Select Health Plans  
October 1, 2011

EasyChoice Plan

Benefits that have changed are highlighted in gray    Ded + Coin = Deductible + Coinsurance    — Applies to all plans as shown —  
IN = In-network    OUT = Out-of-network    PCY = Per Calendar Year    OT = Occupational therapy    PT = Physical therapy

Provider Network	EasyChoice A Heritage		EasyChoice B Heritage		EasyChoice C Foundation		
	IN	OUT	IN	OUT	IN	OUT	
<b>Copayments, Deductible &amp; Coinsurance</b>							
<b>Copayments</b>							
Office Visit	\$15*	50%	\$30*	50%	\$35*	50%	
Inpatient Copay	Individual	—————		None	—————		
	Family	—————		N/A	—————		
Outpatient Surgery Copay		—————		None	—————		
ER Copay (waived if admitted)	\$100	\$100	\$150	\$150	\$200	\$200	
<b>Deductible</b>							
Deductible PCY	Individual	\$1,000	\$2,000	\$750	\$1,500	\$0	\$250
	Family	\$3,000	\$6,000	\$2,250	\$4,500	\$0	\$750
<b>Coinsurance</b>							
Coinsurance		20%	50%	25%	50%	35%*	50%
Out-of-Pocket Maximum PCY**	Individual	\$5,000	None	\$4,000	None	\$7,500	None
	Family	\$15,000	None	\$12,000	None	\$22,500	None
<b>Covered Services</b>							
<b>Office Visits – Professional Care</b>							
Medical and Naturopathic Office Visits unlimited	\$15*	50%	\$30*	50%	\$35*	50%	
Spinal and Other Manipulations 12 visits PCY (chiropractic)	\$15*	50%	\$30*	50%	\$35*	50%	
Acupuncture 12 visits PCY	\$15*	50%	\$30*	50%	\$35*	50%	
<b>Preventive Care</b> unlimited							
Exams/Immunizations	—————		IN: \$0*	OUT: Not covered	—————		
Preventive Screenings (includes mammography and colon health screenings)	—————		IN: \$0*	OUT: 50%	—————		
<b>Diagnostic Services</b>							
Diagnostic Imaging/Laboratory	Paid in full to \$1,000 then Ded + Coin		—————		Ded + Coin	—————	
<b>Hospital/Facility Care</b>							
Outpatient	—————		—————		Ded + Coin	—————	
Inpatient	—————		—————		Ded + Coin	—————	
Maternity – Prenatal/Postnatal Care	—————		—————		Ded + Coin	—————	
Maternity – Delivery	—————		—————		Ded + Coin	—————	
<b>Emergency Care</b>							
Professional/Facility	—————		—————		ER Copay + Ded + Coin	—————	
Ambulance (air and ground)	—————		—————		Ded + Coin	—————	
<b>Mental Health Outpatient</b> unlimited visits	\$15*	50%	\$30*	50%	\$35*	50%	
<b>Mental Health Inpatient</b> unlimited days	—————		—————		Ded + Coin	—————	
<b>Rehabilitation Outpatient</b> A:30 visits PCY, B&C: 45 visits PCY (PT, Massage, Speech, OT)	\$15*	50%	\$30*	50%	\$35*	50%	
<b>Rehabilitation Inpatient</b> A: 30 days PCY, B&C: 45 days PCY	—————		—————		Ded + Coin	—————	
<b>Prescription Drugs</b> (participating pharmacies only)							
		Generic / Preferred Brand Name / Non-preferred Brand Name					
Rx Deductible (waived for generics) per person PCY	\$500		\$250		\$500		
Rx Out-of-Pocket Maximum per person PCY; includes Rx deductible, coinsurance and/or copay	—————		—————		\$5,000	—————	
Retail Cost Share 30 day supply	\$0 / 30% / 30%		—————		\$0 / 30% / 45%		
Mail Order Cost Share 90 day supply	\$0 / 25% / 25%		—————		\$0 / 75% / 112%		
Specialty Drug Cost Share 30 day supply	—————		—————		30%	—————	
<b>Unum</b> (Life & AD&D insurance)†	—————		—————		\$12,500 Term Life and AD&D for employee only	—————	

\* Not subject to the calendar year deductible

\*\* Out-of-pocket maximums include coinsurance and deductible. Covered in-network services paid at 100% of allowable charges for remainder of the calendar year once out-of-pocket maximum is met. No out-of-pocket maximum 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.

020684 (07-2011)

Premera Blue Cross is an Independent Licensee of the Blue Cross Blue Shield Association

# Premera Blue Cross WEA Select Plan 5

All benefit changes effective October 1, 2011

Benefits that have changed are highlighted in gray Ded + Coin = Deductible + Coinsurance Applies to in- and out-of-network  
 IN = In-network OUT = Out-of-network PCY = Per Calendar Year OT = Occupational therapy PT = Physical therapy

## Foundation Provider Network

Copayments, Deductible & Coinsurance		IN	OUT
<b>Copayments</b>			
Office Visit		\$15*	30%
Inpatient Copay	Individual	————— \$200 per admission, \$600 Max PCY —————	
	Family	————— \$1,000 PCY —————	
Outpatient Surgery Copay		————— None —————	
ER Copay (waived if admitted)		————— \$50 —————	
<b>Deductible</b>			
Deductible PCY	Individual	\$100	\$250
	Family	\$300	\$250 /family member
<b>Coinsurance</b>			
Coinsurance		0%	30%
Out-of-Pocket Maximum PCY**	Individual	Ded + \$0	None
	Family	————— N/A —————	
Covered Services		IN	OUT
<b>Office Visits – Professional Care</b>			
Medical and Naturopathic Office Visits	unlimited	\$15*	30%
Spinal and Other Manipulations	unlimited visits (chiropractic)	\$15*	30%
Acupuncture	unlimited visits	\$15*	30%
<b>Preventive Care</b> unlimited			
Exams/Immunizations		\$0*	Not covered
Preventive Screenings (includes mammography and colon health screenings)		\$0*	30%
<b>Diagnostic Services</b>			
Diagnostic Imaging/Laboratory		————— Ded + Coin —————	
<b>Hospital/Facility Care</b>			
Outpatient		————— Ded + Coin —————	
Inpatient		————— Inpatient Copay + Ded + Coin —————	
Maternity – Prenatal/Postnatal Care		————— Ded + Coin —————	
Maternity – Delivery		————— See Outpatient or Inpatient Hospital/Facility Care —————	
<b>Emergency Care</b>			
Professional/Facility		————— ER Copay + Ded + Coin —————	
Ambulance (air and ground)		————— Deductible +\$50 —————	
Mental Health Outpatient	unlimited visits	\$15*	30%
Mental Health Inpatient	unlimited days	————— Inpatient Copay + Ded + Coin —————	
Rehabilitation Outpatient	45 visits PCY (PT, Massage, Speech, OT)	\$15*	30%
Rehabilitation Inpatient	30 days PCY	————— Inpatient Copay + Ded + Coin —————	
Prescription Drugs (participating pharmacies)		Generic / Preferred Brand Name / Non-preferred Brand Name	
Rx Deductible	per person PCY	————— None —————	
Rx Out-of-Pocket Maximum	per person PCY	————— N/A —————	
Retail Cost Share	30 day supply	————— \$10 / \$15 / \$30 —————	
Mail Order Cost Share	90 day supply	————— \$10 / \$30 / \$60 —————	
Specialty Drug Cost Share	30 day supply	————— Subject to applicable retail copay —————	
<b>Unum</b> (Life & AD&D insurance)†		\$12,500 Term Life and AD&D for employee only	

\* Not subject to the calendar year deductible

\*\* 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.

