Effective July 1, 2010

health care coverage

For Individuals and Families in Washington.

PREMERA BLUE CROSS

Choosing the health plan that's best for you —

To enroll in a Premera Blue Cross Individual health plan:

1. Review the following summary of benefits and compare the benefit options.
2. Select the plan and deductible that is best for you.
3. Review the separate rate sheet for your plan selection to determine your monthly rate.
4. Complete the Enrollment Application.
5. Complete the Standard Health Questionnaire for Washington state for each family member you wish to enroll.
6. Sign, date and return all of the information in the enclosed return envelope.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month.

PCY = Per Calendar Year

[1] Family deductible = 3x Individual

[2] After the coinsurance maximum is met, in-network providers are covered in full.

[3] Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

[4] Benefits are limited to services received in the following locations:

- A hospital (inpatient or outpatient)
- Ambulatory surgical center
- Emergency room
- Skilled nursing facility

Note: All coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross.

MEDICAL BENEFITS

Annual Deductible per individual PCY

Coinsurance

Annual Coinsurance Maximum[2] PCY

Lifetime Benefit Maximum

COVERED SERVICES

PREVENTIVE CARE

Preventive Care Exam

Immunizations

PROFESSIONAL CARE

Office Visit Including Urgent Care

Other Outpatient Professional Services

Inpatient Professional Services

PHARMACY

Retail and Mail Order $5,000 PCY (If applicable)
(separate annual deductible applies; prescriptions limited to 30-day supply)

VISION

Routine Vision Exam

Vision Hardware (frames, lenses and contacts)

DIAGNOSTIC SERVICES

Diagnostic X-ray and Laboratory Services

Mammography

Cancer Screening and Cholesterol Screening (including PAP smears, PSA testing, colorectal cancer screening and cholesterol screening)

FACILITY CARE

Inpatient Facility

Outpatient Surgery Facility

Skilled Nursing Facility

EMERGENCY CARE

Emergency Care (copay waived if direct admit to an inpatient facility)

Ambulance Transportation

OTHER SERVICES

Maternity Care including prenatal care

Spinal and Other Manipulations

Acupuncture

Supplies, Equipment and Prosthetics

Home Health Care

Hospice Care (6-month maximum)

Rehabilitation (including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain.)

Transplants (Organ & Bone Marrow)
12-month waiting period; $350,000 lifetime benefit

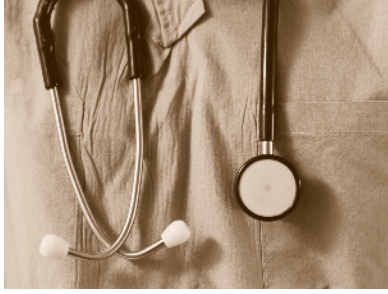
Mental Health—Outpatient

Mental Health—Inpatient

Deductible, coinsurance and copay represent **what you pay**. Benefits apply after calendar year deductible is met, unless otherwise noted.

HERITAGE PROTECTOR PLUS 20		HERITAGE VALUE PLUS 30	
IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
☐ $500 or ☐ $1,000 (choose one)[1]	$1,000 or $2,000[1]	☐ $2,500, ☐ $5,000 or ☐ $10,000 (choose one)	Shared with in-network deductible
20%	50%	30%	50%
$2,000 Individual / $6,000 Family	Unlimited	$6,000	Unlimited
$2 Million		$2 Million	
Deductible waived; 20% (1 visit PCY)	50% (limit shared with in-network)	Not covered	
Not covered			
Not covered		30%	50%
20%[4]	50%[4]		
20%	50%		
Not covered		After $500 prescription drug deductible, member pays: Tier 1 = 20% (generic drugs); Tier 2 = 30% (preferred brand-name drugs); Tier 3 = 50% (non-preferred brand-name drugs)	
Not covered		Not covered	
Not covered			
20%[4]	50%[4]	30%	50%
20%[4]	50%[4]		
Deductible waived; 20%[4]			
20%	50%	30%	50%
20%[4]	50%[4]		
20% (7 days PCY)	50% (limit shared with in-network)	30% (20 days PCY)	50% (limit shared with in-network)
20%		$100 Copay plus 30%	
20% ($500 PCY)		30% ($5,000 PCY)	
Not covered		Not covered	
		30% (12 visits PCY)	50% (limit shared with in-network)
20%[4]	50%[4]	30% ($5,000 PCY)	
20% (60 Home Health visits PCY)	50% (limit shared with in-network)	30% (130 Home Health visits PCY)	
Not covered	Not covered	30% (Inpatient: 10 days max; Respite: 240 hrs max)	
20% (Inpatient only, 15 days PCY)	50% (limit shared with in-network)	30% (Outpatient: 15 visits PCY; Inpatient: 10 days PCY)	
20%[4]	Not covered	30%	Not covered
20%[4]	50%[4]		50%
20%	50%		

HERITAGE PREFERRED PLUS 30		HERITAGE PREFERRED PLUS 20	
IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
$1,000	Shared with in-network deductible	$1,000	Shared with in-network deductible
30%	50%	20%	50%
$3,000	Unlimited	$2,000	Unlimited
$2 Million		$2 Million	
Covered in full[3] ($200 PCY)	Not covered	Covered in full[3] ($300 PCY)	Not covered
30%	50%	20%	50%
After $500 prescription drug deductible, member pays: Tier 1 = 20% (generic drugs); Tier 2 = 30% (preferred brand-name drugs); Tier 3 = 50% (non-preferred-brand-name drugs)		After $200 prescription drug deductible, member pays: Tier 1 = 20% (generic drugs); Tier 2 = 30% (preferred brand-name drugs); Tier 3 = 50% (non-preferred brand-name drugs)	
Covered in Full[3] (one exam per 2 calendar years)		Covered in Full[3] (one exam per 2 calendar years)	
Covered in Full[3] ($200 per 2 calendar years)		Covered in Full[3] ($200 per 2 calendar years)	
30%	50%	20%	50%
Deductible waived; 30%		Deductible waived; 20%	
30%	50%	20%	50%
30% (20 days PCY)	50% (limit shared with in-network)	20% (45 days PCY)	50% (limit shared with in-network)
$100 Copay plus 30%		$100 Copay plus 20%	
30% ($5,000 PCY)		20% ($5,000 PCY)	
30%	50%	20%	50%
30% (12 visits PCY)	50% (limit shared with in-network)	20% (12 visits PCY)	50% (limit shared with in-network)
30% ($5,000 PCY)		20% ($5,000 PCY)	
30% (130 Home Health visits PCY)		20% (130 Home Health visits PCY)	
30% (Inpatient: 10 days max; Respite: 240 hrs. max)		20% (Inpatient: 10 days max; Respite: 240 hrs. max)	
30% (Outpatient: 15 visits PCY; Inpatient: 10 days PCY)		20% (Outpatient: 20 visits PCY; Inpatient: 8 days PCY)	
30%	Not covered	20%	Not covered
	50%		50%



Premera Blue Cross and you

For more than 70 years, Premera Blue Cross has been providing quality health care coverage to the residents of Washington state.

We understand how important it is to have the right health plan—one that meets the needs of your family, as well as your budget. That's why we offer you a range of coverage options and price levels.

A choice of plans

You can choose between four health plan options with different deductibles to get the coverage that suits your needs.

Heritage Protector Plus™ 20 offers you catastrophic coverage in the event of major illness or accident. Preventive care is covered up to one visit per person, per calendar year.

Heritage Value Plus™ 30 is a low-cost option that provides coverage primarily for illness or injuries. Preventive care is not covered under this plan. You can choose from three deductibles.

Heritage Preferred Plus™ 30 provides coverage for routine services—including preventive care—and major medical, and has a 30% coinsurance when network providers are used.

Heritage Preferred Plus™ 20 offers coverage for routine services—including preventive care—and major medical, with a 20% coinsurance when network providers are used.

This is only a summary of the major benefits provided by our plans. It is not a contract.

Expansive provider networks

All of our plans offer you access to statewide and nationwide networks that offer valuable discounts on billed charges—so you can save money.

Our Heritage network includes thousands of doctors, hospitals and other health care providers throughout the state, including rural areas.

When you travel, you can use a nationwide network of Blue Cross Blue Shield-contracted providers that are part of the BlueCard® Program.

Extras! Discounts for Members

To compliment your health plan, we've negotiated special discounts from **10 – 60% off** on health and wellness products and services. **To learn more, visit *premera.com*.**

Who is eligible

Premera Blue Cross Individual health plans are available to all permanent Washington state residents, except in Clark County. Eligible family members include your spouse and unmarried children under age 25.

(There is a 9-month waiting period for pre-existing conditions.)

We're here. We're with you.

Contact your Premera Blue Cross producer today for more information or for help with enrollment.

Or, call us direct at 800-752-6663.

What is not covered

Benefits are not provided for treatment, surgery, services, drugs or supplies for any of the following:

- Learning disorders
- Neurodevelopmental disabilities
- Chemical dependency or tobacco addiction
- Infertility
- Sexual dysfunction
- Sterilization or its reversal
- Maternity/Obstetrical care (except for complications of pregnancy) not covered on Heritage Value Plus or Heritage Protector Plus plans
- Obesity/morbid obesity
- Cosmetic or reconstructive surgery (except as specifically provided)
- Dental services (except as specifically provided)
- Vision exams and eyewear not covered on Heritage Value Plus or Heritage Protector Plus plans
- Hearing examinations or hardware
- Temporomandibular joint disorder (TMJ)
- Orthognathic surgery
- Services payable by other types of insurance coverage
- Experimental or investigative services
- Over-the-counter or non-prescription drugs
- Services in excess of specified benefit maximums
- Services received when you are not covered by this program

Premera Blue Cross

800-752-6663

TDD/TTY for the hearing impaired:
800-842-5357

7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Mailing Address:
P.O. Box 327
Seattle, WA 98111-0327

005914 (02-2010)