



WEA Select Health Plans

Summary of Benefits and Rates

NOVEMBER 1, 2014 – OCTOBER 31, 2015



BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association



Helpful definitions

Allowable Charge The maximum amount Premera will pay for a covered service or supply.

Calendar Year A 12-month period, running from January 1 through December 31, when medical expenses are incurred that count toward specific annual benefit maximums, limitations, deductibles and out-of-pocket maximums.

Coinsurance The percentage of a covered service you pay after your deductible has been met.

Copay The fixed dollar amount you pay each time you use certain services.

Deductible The amount you pay each year before your plan starts to pay benefits toward certain services.

Deductible Carryover Deductible expenses you incur in the last two months of a calendar year will be applied toward or “carried over” to the next calendar year’s deductible. Note: WEA Select QHDHP does not have a deductible carryover provision.

Network Your plan’s contracted provider network (Heritage or Foundation) determines which doctors, hospitals, and other healthcare providers are covered at your plan’s in-network benefit level.

Heritage WEA Select Plans 2, 3, and EasyChoice A and B

Foundation WEA Select Plan 5, EasyChoice C, and QHDHP

Out-of-pocket Maximum The maximum amount you pay out of your own pocket for medical copays, deductible and coinsurance in a calendar year, excluding prescription drug costshares.

Plan Year The 12-month period in which benefits and rates are contracted, running from November 1 through October 31.

Note: This Summary of Benefits 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.

Find the plan that works for you

Reviewing your coverage each year is a good way to make sure you've got the health plan that best fits your healthcare needs. As you review your WEA Select Plan options for the 2014–2015 school year, below are some important things to consider:

Key features for in-network services

Copay, deductible, and coinsurance amounts represent **what you pay**. Benefits are subject to the deductible unless otherwise noted.

Plans 5, 2, and 3

Deductible does not apply to office visits, preventive care, or prescription drugs.

Plan 5

- Foundation provider network
- \$15 office visit copay
- Low deductible
- 10% coinsurance
- Lowest out-of-pocket maximum

Plan 2

- Heritage provider network
- \$25 office visit copay
- Low deductible
- 20% coinsurance
- Moderate out-of-pocket maximum

Plan 3

- Heritage provider network
- \$30 office visit copay
- Moderate deductible
- 20% coinsurance
- Higher out-of-pocket maximum

EasyChoice Plan

Deductibles do not apply to office visits, preventive care, or generic prescription drugs. There are no cost shares for generic prescriptions. There is a separate deductible for brand-name prescriptions.

EasyChoice A

- Heritage provider network
- \$15 office visit copay
- High deductible
- 20% coinsurance
- 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 copay
- Moderate deductible
- 25% coinsurance
- Lowest prescription drug deductible

EasyChoice C

- Foundation provider network
- \$35 office visit copay
- Low deductible
- 35% coinsurance
- Coverage for hearing exams and hardware

Qualified High Deductible Health Plan (QHDHP)

Deductible does not apply to in-network preventive care. **All** other services, including prescription drugs, are subject to the deductible. You pay 100% of all costs until your (or your family) deductible is met.

- Foundation provider network
- High deductible
- 20% coinsurance after deductible is met (no copays)
- Designed to work with a Health Savings Account (HSA)

Provider networks

Your WEA Select Medical Plan uses a network of contracted, or in-network, providers to provide healthcare services to you.

In-network providers agree not to bill for amounts over the allowable charge. Be sure to use an in-network provider for the highest level of benefits from your health plan and lower out-of-pocket costs. WEA Select Plan enrollees also have access to in-network providers nationally and worldwide through the BlueCard program.

Your plan also includes an out-of-network option for most services. When you use a licensed healthcare provider who is not in your plan's network, their services are covered at a lower level of benefits. You may also be responsible for amounts over Premera's allowable charge. This is often known as balance billing.

What provider network does your medical plan use?

Heritage WEA Select Plans 2, 3, and EasyChoice A and B

Foundation WEA Select Plan 5, EasyChoice C, and QHDHP

The Heritage network includes UW Physicians and hospitals, and Seattle Cancer Care Alliance/Fred Hutchinson. The Foundation network does not include these providers.

Who's in-network at your local hospital?

Some in-network hospitals subcontract with out-of-network providers (e.g., emergency room (ER) physicians, anesthesiologists, assistant surgeons and radiologists). Premera always covers emergency care at the in-network benefit level. However, if you receive care from an out-of-network provider, you may be responsible for amounts over Premera's allowable charge, even if the hospital is in-network.

Pharmacy

Your prescription drug benefit

WEA Select Medical Plans provide access to a wide range of generic and brand-name prescription drugs at over 64,000 in-network retail pharmacies across the country.

These drugs are separated into three tiers: generic, preferred brand name, and non-preferred brand name. Your copay (a set amount) or coinsurance (a percentage of the cost) depends on the WEA Select Plan you choose and the drug's tier. Prescription benefit details for each WEA Select Plan can be found in the benefit summary of this brochure.

To find out which tier your drug is in, use the Rx Search tool in the Pharmacy section at premera.com/wea. WEA Select Plans use the "Preferred B3" drug list.

Prescription drug tiers

Tier 1 Lowest out-of-pocket cost

Generic drugs	Generic drugs meet the same FDA safety and effectiveness standards as brand-name drugs because they use the same active ingredients.
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Tier 2 Moderate out-of-pocket cost

Preferred brand-name drugs	Your doctor may prescribe these drugs if there is no generic option. Or your doctor might decide a brand-name drug is best for you.
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Tier 3 Highest out-of-pocket cost

Non-preferred brand-name drugs	Often have Tier 1 or Tier 2 alternatives. These drugs may be more expensive than their alternatives in Tier 1 or Tier 2. Also includes new drugs not yet reviewed for their safety and effectiveness.
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Specialty drugs

Many people with complex conditions—such as multiple sclerosis, rheumatoid arthritis, and cancer—require special medications. These medications are frequently self-administered and can be expensive. Typically, they are not readily available at a local pharmacy and may require special handling. Specialty drugs can be dispensed by one of our preferred specialty pharmacies or from a participating retail pharmacy. If you are currently taking a specialty drug, or may in the future, get more information about our:

- specialty pharmacy program,
- preferred specialty pharmacies, and
- list of specialty drugs

by visiting premera.com/wea or calling Premera Customer Service at 800-932-9221.

Benefit changes

EFFECTIVE NOVEMBER 1, 2014

All WEA Select Medical Plans

Out-of-Pocket Maximum includes copays

Medical copays will accrue to each plan's annual out-of-pocket maximum, excluding prescription drug costshares.

2013-14 benefit year	New 2014-15 benefit year
Annual out-of-pocket maximum includes deductible and coinsurance expenses.	Annual out-of-pocket maximum includes medical copays , deductible and coinsurance expenses.

EasyChoice Plans only

Lower Out-of-Pocket Maximum

Annual out-of-pocket maximums for in-network services will **decrease** as shown below saving EasyChoice Plan enrollees money on their annual healthcare costs.

	2013-14 benefit year	New 2014-15 benefit year
EasyChoice Plan A	\$5,000/individual or \$15,000/family PCY	\$4,000/individual or \$12,000/family PCY
EasyChoice Plan B	\$4,000/individual or \$12,000/family PCY	\$3,500/individual or \$10,500/family PCY
EasyChoice Plan C	\$7,500/individual or \$22,500/family PCY	\$4,200/individual or \$12,600/family PCY

PCY = Per Calendar Year

EasyChoice Plan C deductible

For EasyChoice Plan C only, we've added an in-network deductible of \$100 per person or \$300 per family PCY for covered services such as hospital charges or diagnostic lab & x-ray services. Medical office visits and preventive care are not subject to the deductible.

Make sure you're covered

Don't be surprised by a bill you weren't expecting

Did you know that some services and procedures need to be reviewed by Premera before you get them? This review is called Prior Authorization, and it ensures that the services your doctor is recommending are covered for your condition. Starting November 1, 2014, Prior Authorization is required for some planned services. Your healthcare provider is familiar with the process for getting a Prior Authorization, so it's best if your doctor contacts Premera on your behalf. You should always ask your healthcare provider about requesting a Prior Authorization before you schedule a planned service or procedure.

Prior Authorization helps you:

- Find out if your procedure is covered by your plan before you have it
- Get an estimate of your out-of-pocket costs
- Avoid unnecessary services

Some services that require a Prior Authorization

- Planned admission into hospitals or skilled nursing facilities
- Non-emergency ground or air ambulance transport
- Advanced imaging, such as MRIs and CT scans
- Transplant and donor services
- Home medical equipment costing \$500 or more
- Some planned outpatient procedures

Some services that do not need a Prior Authorization

- Maternity care
- Hospital admission for childbirth and newborn care
- Emergency admission into hospital
- Emergency room services
- Routine preventive care
- Outpatient rehabilitation

The list above is not complete and shows just some of the services that require a Prior Authorization.

A more complete list can be found at premera.com/wea. Keep in mind, your doctor has the most current list and medical information needed to request a Prior Authorization on your behalf.

Provider Network		Plan 5 Foundation		Plan 2 Heritage		Plan 3 Heritage	
Copayments, Deductible & Coinsurance		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Copayments							
Office Visit		\$15*	30%	\$25*	\$30*	\$30*	\$40*
Inpatient Copay	Individual	\$200 per admission, \$600 Max PCY	None	\$150 per day, \$450 Max PCY		\$300 per day, \$900 Max PCY	
	Family		N/A				
Outpatient Surgery Copay			None	\$100		\$150	
ER Copay (waived if admitted)			\$50	\$75		\$100	
Deductible							
Deductible PCY	Individual	\$200	\$350	\$200 combined In-Net.+Out-of-Net.		\$300 combined In-Net.+Out-of-Net.	
	Family	\$600	\$350/family member	\$600 combined In-Net.+Out-of-Net.		\$900 combined In-Net.+Out-of-Net.	
Coinsurance							
Coinsurance		10%	30%	20%	40%	20%	40%
Out-of-Pocket Maximum PCY**	Individual	\$500	None	\$1,500 combined		\$2,750 combined	
	Family	\$1,500	None	\$4,500 combined		\$8,250 combined	
Covered Services		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Office Visits—Professional Care							
Medical and Naturopathic Office Visits unlimited							
Spinal and Other Manipulations (chiropractic)		\$15*	30%	\$25*	\$30*	\$30*	\$40*
Acupuncture 12 visits PCY (Plan 5 unlimited visits)							
Preventive Care							
Exams/Immunizations							
Preventive Screenings (includes mammography and colon health screenings)		\$0*	Not covered	\$0*	20%*	\$0*	20%*
Diagnostic Services							
Diagnostic Imaging/Laboratory		Ded + Coin		Ded + Coin		Ded + Coin	
Hospital/Facility Care							
Outpatient		Ded + Coin		Outpatient Surgery Copay+Ded+Coin		Outpatient Surgery Copay+Ded+Coin	
Inpatient		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Maternity—Prenatal/Postnatal Care		Ded + Coin	Ded + Coin	Ded + Coin		Ded + Coin	
Maternity—Delivery (newborns have their own copays, deductibles, and coinsurance)		Inpatient Copay + Ded + Coin	Ded + Coin	See Outpatient or Inpatient Hospital/Facility Care		See Outpatient or Inpatient Hospital/Facility Care	
Emergency Care							
Professional/ Facility		ER Copay + Ded + Coin		ER Copay + Ded + Coin		ER Copay + Ded + Coin	
Ambulance (air and ground)		Deductible +\$50		Ded + Coin		Ded + Coin	
Other Services							
Mental Health Outpatient unlimited visits		\$15*	30%	\$25*	\$30*	\$30*	\$40*
Mental Health Inpatient unlimited days		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Rehabilitation Outpatient 45 visits PCY (PT, Massage, Speech, OT) (2 & 3: PT unlimited)		\$15*	30%	\$25* PT Ded + Coin	\$30* PT Ded + Coin	\$30* PT Ded + Coin	\$40* PT Ded + Coin
Rehabilitation Inpatient 5&3: 30 days PCY, 2: 120 days PCY		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Prescription Drugs (participating pharmacies)		Generic / Preferred Brand Name / Non-preferred Brand Name					
Rx Deductible per person PCY		None		None		None	
Rx Out-of-Pocket Maximum per person PCY		N/A		N/A		N/A	
Retail Cost Share		\$10 / \$15 / \$30 (30 day supply)		\$10 / \$20 / \$35 (34 day supply)		\$15 / \$25 / \$40 (34 day supply)	
Mail Order Cost Share		\$10 / \$30 / \$60 (90 day supply)		\$10 / \$20 / \$35 (100 day supply)		\$15 / \$25 / \$40 (100 day supply)	
Specialty Drug Cost Share 30 day supply		Subject to applicable retail copay		Subject to applicable retail copay		Subject to applicable retail copay	
Unum Life and 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 medical copays, deductible and coinsurance. Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the calendar year. Plans 2 & 3 pay covered out-of-network services on same basis. There is no out-of-pocket maximum for Plan 5 for out-of-network services. Prescription drug copays do not accrue to the medical out-of-pocket maximum.

Provider Network		EasyChoice A Heritage		EasyChoice B Heritage		EasyChoice C Foundation	
Copayments, Deductible & Coinsurance		In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Copayments							
Office Visit		\$15*	50%	\$30*	50%	\$35*	50%
Inpatient Copay	Individual		None		None		None
	Family		N/A		N/A		N/A
Outpatient Surgery Copay			None		None		None
ER Copay (waived if admitted)			\$100		\$150		\$200
Deductible							
Deductible PCY	Individual	\$1,000	\$2,000	\$750	\$1,500	\$100	\$250
	Family	\$3,000	\$6,000	\$2,250	\$4,500	\$300	\$750
Coinsurance							
Coinsurance		20%	50%	25%	50%	35%	50%
Out-of-Pocket Maximum PCY**	Individual	\$4,000	None	\$3,500	None	\$4,200	None
	Family	\$12,000	None	\$10,500	None	\$12,600	None
Covered Services							
Office Visits—Professional Care							
Medical and Naturopathic Office Visits unlimited							
Spinal and Other Manipulations 12 visits PCY (chiropractic)		\$15*	50%	\$30*	50%	\$35*	50%
Acupuncture 12 visits PCY							
Preventive Care							
Exams/Immunizations		\$0*	Not covered	\$0*	Not covered	\$0*	Not covered
Preventive Screenings (includes mammography and colon health screenings)		\$0*	50%	\$0*	50%	\$0*	50%
Diagnostic Services							
Diagnostic Imaging/Laboratory		Paid in full to \$1,000 then Ded + Coin		Ded + Coin		Ded + Coin	
Hospital/Facility Care							
Outpatient							
Inpatient			Ded + Coin		Ded + Coin		Ded + Coin
Maternity—Prenatal/Postnatal Care			Ded + Coin		Ded + Coin		Ded + Coin
Maternity—Delivery (newborns have their own deductibles and coinsurance)							
Emergency Care							
Professional / Facility		ER Copay + Ded + Coin		ER Copay + Ded + Coin		ER Copay + Ded + Coin	
Ambulance (air and ground)		Ded + Coin		Ded + Coin		Ded + Coin	
Other Services							
Mental Health Outpatient unlimited visits		\$15*	50%	\$30*	50%	\$35*	50%
Mental Health Inpatient unlimited days		Ded + Coin		Ded + Coin		Ded + Coin	
Rehabilitation Outpatient A: 30 visits PCY, B & C: 45 visits PCY (PT, Massage, Speech, OT)		\$15*	50%	\$30*	50%	\$35*	50%
Rehabilitation Inpatient A: 30 days PCY, B & C: 45 days PCY		Ded + Coin		Ded + Coin		Ded + Coin	
Prescription Drugs** (participating pharmacies)							
		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		\$5,000		\$5,000	
Retail Cost Share		\$0 / 30% / 30% (30 day supply)		\$0 / \$30 / \$45 (30 day supply)		\$0 / \$30 / \$45 (30 day supply)	
Mail Order Cost Share		\$0 / 25% / 25% (90 day supply)		\$0 / \$75 / \$112 (90 day supply)		\$0 / \$75 / \$112 (90 day supply)	
Specialty Drug Cost Share		30% (30 day supply)		30% (30 day supply)		30% (30 day supply)	
Unum Life and AD&D Insurance							
		\$12,500 Term Life and AD&D for employee only					

* Not subject to the calendar year deductible

** EasyChoice Plans have separate deductibles and out-of-pocket maximums for medical and prescription drugs. In-network medical out-of-pocket maximums include copays, deductible and coinsurance. Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the calendar year. There is no out-of-pocket maximum for out-of-network services. Prescription drug out-of-pocket maximums include Rx deductible, coinsurance and/or copays.

WEA Select Qualified High Deductible Health Plan (QHDHP)

- Foundation provider network
- Designed to work with a Health Savings Account (HSA)*
- Dual WEA coverage not allowed if you are enrolled in QHDHP
- No deductible carryover

Deductible

- QHDHP deductible and out-of-pocket maximum are set by federal guidelines.
- You pay 100% of all costs (except in-network preventive care) until your deductible is met.
- If you cover any dependent(s), benefits do not begin until your **family** deductible is met.

Coinsurance

After you satisfy your (or your family) deductible, you pay 20% of covered services until you reach the plan's out-of-pocket maximum.

Out-of-pocket maximum

- Out-of-pocket maximum includes deductible and coinsurance.
- Once your annual out-of-pocket maximum is met, all covered services are paid in full for the remainder of the calendar year.
- If you cover any dependent(s), services are not covered in full for any family member until your **family** out-of-pocket maximum is met.

Before enrolling in QHDHP, consider:

- Are you able to pay 100% of your healthcare costs until your deductible is met?
- Only in-network preventive services are covered in full.
- Review your claims information and Spending Activity Report from the previous year. Log in to premera.com/wea.
- Include any elective services planned in the next year, such as surgeries or maternity care.

* An HSA is an account you fund to pay for current health expenses not covered by your medical plan, such as deductible and out-of-pocket expenses. For more detailed information, refer to IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans, available at www.irs.gov. Consult your tax advisor to determine tax implications of participating in an HSA.

Provider Network **QHDHP**
Foundation

Cost Shares		In-Network	Out-of-Network
Deductible			
Deductible PCY	Individual	\$1,500	\$3,000
	Family	\$3,000	\$6,000
Deductible Carryover		Not Available	Not Available
Coinsurance			
Coinsurance		20%	50%
Out-of-Pocket Maximum (PCY)	Individual	\$4,000	None
	Family	\$8,000	

Out-of-Pocket maximum includes in-network deductible/coinsurance and prescription drug coinsurance. There is no out-of-pocket maximum for out-of-network services.

Cost share amounts represent what you pay. All services subject to deductible except as noted.*

Covered Services	In-Network	Out-of-Network
Preventive Care		
Exams/Immunizations	\$0*	Not covered
Preventive Screenings		50%
Professional Care		
Office Visit		
Outpatient Professional Services	20%	50%
Inpatient Professional Services		
Alternative Care		
Manipulations (Spinal & Other) 12 visits PCY		
Acupuncture 12 visits PCY	20%	50%
Naturopathic Services		
Diagnostic Services		
Mammography (Non-preventive)	20%	50%
Outpatient Diagnostic Imaging & Laboratory Services		
Emergency Care		
Emergency Care	20%	20%
Ambulance (Air or ground)		
Facility Care		
Inpatient Care	20%	50%
Outpatient Facility Care		
Maternity		
Maternity—Prenatal Care/Postnatal Care/Delivery (newborns have their own deductibles and coinsurance)	20%	50%
Other Services		
Mental Health Care (Inpatient/outpatient)		
Rehabilitation (Physical, Occupational, Speech, and Massage Therapy) Outpatient: 15 visits PCY; Inpatient: 30 days PCY	20%	50%
Prescription Drugs (Subject to medical deductible)		
Retail Pharmacy Up to 30 day supply		
Mail Order Pharmacy Up to 90 day supply	20%	20%
Specialty Drugs Up to 30 day supply		

Note: A few generic prescription drugs are not subject to deductible and are covered in full.

Unum Life and AD&D Insurance	\$12,500 Term Life and AD&D for employee only
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* Not subject to the calendar year deductible

PCY = Per Calendar Year

WEA Select Medical Plan monthly rates

Medical rates listed do not include any amounts made available through the State Fringe Benefit Allocation or district pooling.

The average overall monthly rate increase for all WEA Select Medical Plans is 7.9%.

The 10% discount rates are available to school districts/employee groups when only the WEA Select Premiera Blue Cross Medical Plans and one licensed HMO plan from one HMO carrier are offered.

The full rates apply to all groups that do not meet the discount requirements.

Check with your district to find out if the discount rates are available to you.

WEA Plan		10% Discount	Full
Plan 5	Employee only	\$979.85	\$1,088.70
	Employee / Spouse	\$1,882.45	\$2,090.30
	Employee / Spouse / Child(ren)	\$2,267.65	\$2,518.05
	Employee / Child(ren)	\$1,336.75	\$1,485.00
Plan 2	Employee only	\$837.75	\$926.10
	Employee / Spouse	\$1,532.75	\$1,698.80
	Employee / Spouse / Child(ren)	\$1,837.50	\$2,037.25
	Employee / Child(ren)	\$1,118.25	\$1,237.80
Plan 3	Employee only	\$749.70	\$829.40
	Employee / Spouse	\$1,371.80	\$1,520.40
	Employee / Spouse / Child(ren)	\$1,644.55	\$1,823.25
	Employee / Child(ren)	\$1,000.85	\$1,108.45
EasyChoice A, B and C	Employee only	\$535.25	\$591.85
	Employee / Spouse	\$971.65	\$1,076.65
	Employee / Spouse / Child(ren)	\$1,164.05	\$1,290.20
	Employee / Child(ren)	\$709.80	\$785.50
Qualified High Deductible Health Plan (QHDHP)	Employee only	\$420.90	\$465.25
	Employee / Spouse	\$763.05	\$845.30
	Employee / Spouse / Child(ren)	\$901.45	\$999.05
	Employee / Child(ren)	\$557.75	\$617.10

The WEA/Premera Medical Plan advantage

The WEA is one of the largest insurance purchasing pools in Washington with more than 120,000 enrollees from school districts across the state. As part of a large group, health costs are maintained on a statewide basis and are not tracked by individual bargaining units or school districts. Each group has the advantage of blending their health cost experience into the larger pool of school employees.

For example, last year there were more than 675 WEA enrollees with claims above \$100,000—some of them exceeding \$1 million. A smaller group or pool with a proportionate level of high dollar claims would have faced a substantially greater rate increase than WEA's 7.9% to offset those higher costs.

As a comparison, other Premera large group plans (100+ enrollees) renewing over the first six months of 2014 have seen an average rate increase of 10.5%. Also, Washington's Office of Insurance Commissioner recently announced an average proposed rate increase of 8.25% for plans offered through the Washington Health Benefit Exchange in 2015.

Review your coverage and save money

We encourage you to review your coverage to be sure you've got the health plan that best fits your healthcare needs and budget. For some, this may be the year to consider moving to a lower-cost plan to save money.

Things to consider when comparing health plans

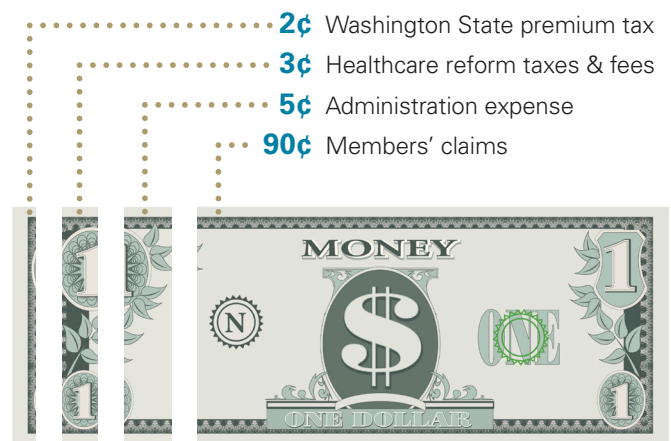
Whether you're comparing WEA plan options or looking at other plans offered by your district, there are several important things to consider when reviewing your choices.

- The deductible/copay/coinsurance you pay
- The maximum you pay "out-of-pocket" each year
- The benefits and services covered by the plan
- Any plan limitations or restrictions
- The provider network and how you access care locally, nationally and worldwide
- Make sure any medications you use are covered*
- The monthly premiums—keep in mind the premiums noted on page 8 are before applying the State Fringe Benefit Allocation or any monies from your insurance pool

* All WEA Select Plans use the same open drug formulary, which covers all FDA approved medications prescribed for a covered condition. No classes of drugs are excluded from coverage due to costs. This allows you and your physician to decide the best treatment for your condition.

Where do your healthcare dollars go?

Ninety cents of every dollar you spend for your healthcare plan goes to pay for WEA Select Plan enrollees' medical claims:



What you can do to keep your healthcare costs down

Use in-network providers

- In-network providers agree to accept our allowable charge as full payment.
- Your out-of-pocket costs are limited to applicable copays, deductible and coinsurance for covered services.
- In-network providers submit your claims for you and we pay them directly.

Use your plan's preventive benefits to help find any conditions before they get serious.

Use the online tools at premera.com/wea to compare costs on medical services and prescription drugs.

Ask your doctor if a generic equivalent is available for your name-brand medication.

Receive maintenance medications by mail. It's not only convenient, it saves you money.

To find an in-network healthcare provider, facility or pharmacy go to premera.com/wea and click on the Find a Doctor tool.

Customer Service

Premera Customer Service
(Benefits and Claims)

premera.com/wea

WEA Select Customer Service
800-932-9221 TDD 800-842-5357

Your Benefits Resources™
(Eligibility and Enrollment)

<http://resources.hewitt.com/wea>

WEA Select Benefits Center
855-668-5039

WEA Plan Consultant:

AON Hewitt

(206) 467-4646

Aon Hewitt, an independent provider of plan consultation and administration services, does not provide Premera Blue Cross products or services. Aon Hewitt is solely responsible for their own services.

Life insurance
underwritten by:

unum™

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