

ASSOCIATION OF WASHINGTON CITIES
SUMMARY OF BENEFITS
AWC HealthFirst™ Plan
\$0 Deductible 100/90/70/10
Effective January 1, 2010



Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a Preferred Plan or Non-Preferred provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. **Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance.** When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year. Refer to your benefits brochure for your specific deductible and out-of-pocket coinsurance amount. Any balances of charges not covered by this plan will be your responsibility to pay. The annual deductible, copays, neurodevelopmental therapy services, outpatient rehabilitation care, and smoking cessation programs do not apply to the maximum out-of-pocket coinsurance amount.

Benefits <i>Non-Preferred Providers include Participating and Non-Contracted.</i>	Preferred Provider	Non-Preferred Provider
Preventive Care \$10 professional copay Routine exams, immunizations, well child care	100%	70%
Professional Services Including diagnostic x-ray and laboratory \$10 per-office visit copay for office, home, and outpatient hospital visits	100%	70%
Hospital Facility *** <i>(Inpatient Facility Subject to a \$150 copay for each admission)</i> Inpatient and outpatient including diagnostic x-ray and laboratory \$75 copay per emergency room visit (waived if admitted)	90%	70%
Acupuncture Limited to 12 visits per calendar year maximum	100%	70%
Ambulance Services **	80%	80%
Blood Bank **	80%	80%
CareEnhance Nurse Advice Line – 24 hr service staffed by registered nurse	1 800 267-6729	
Free & Clear – Tobacco Dependence Program – www.freeclear.com	1 866 QUIT 4 LIFE (784-8454)	
Colorectal Cancer Screening	100% professional 90% facility	70%
Chemical Dependency	100%	70%
Growth Hormone \$25,000 per calendar year maximum	100%	70%
Home Health and Hospice Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	90%	90%
Home Medical Equipment, Protheses and Orthotics	90%	70%
Home Phototherapy – Dependent only	100%	100%
Hospitalization for Dental Services No annual maximum	100% professional 90% facility	70% professional 70% facility
Maternity (provided for the subscriber or spouse) <i>(Special Beginnings Maternity Care Program 1-866-922-2911)</i>	same as any other condition	
Mammography	100% professional 90% facility	70%
Mental Disorders Inpatient/Outpatient <i>(Referral recommended through AWC Employee Assistance Program)</i>	100% professional 90% facility	70%
Neurodevelopmental Therapy (for children age 6 and under) \$5,000 maximum per year	90%	70%

Occupational Injury No lifetime maximum	same as any other condition	
Prescription Drugs Limited to a 34-day supply, must use participating pharmacy	\$4 generic copay \$15 brand-name copay \$35 non-formulary copay	
Mail order maintenance drugs – limited to a 90-day supply	Subject to 2 copays	
Prostate Cancer Screening	100% professional 90% facility	70%
Rehabilitation Inpatient - \$15,000 per condition	100% professional 90% facility	70% professional 70% facility
Outpatient** - \$5,000 per calendar year maximum <i>Massage and Physical Therapy – Are covered when medically necessary when using a contracted provider (prescription required).</i>	90%	70%
Skilled Nursing Facility 90 days per calendar year maximum Subject to \$150 copay per admission (waived if readmitted within 30 days for same condition).	*	100% professional 90% facility
Smoking Cessation** \$500 lifetime maximum	75%	75%
Spinal Manipulations Limit to 15 Spinal Manipulation per cal/year	100%	70%
Transplants \$500,000 lifetime maximum; \$50,000 per transplant donor organ procurement maximum; \$2,500 per transplant travel and lodging maximum No limit on number of retransplants	100% professional 90% facility	70% professional 70% facility

* At this time, this service is provided only by participating providers.

** At this time, these services are provided only by recognized providers.

*** Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Lifetime Maximum: \$2,000,000

Annual Deductible: \$ 0

Annual Out-of-Pocket Coinsurance Amount: \$1000 – The total amount of Coinsurance the Member is responsible to pay during a Year for covered services, after which the Contract will provide Benefits at 100 percent of the Allowed Amount for the remainder of that Year, unless otherwise specified. **The maximum annual out-of-pocket coinsurance amount per family is three times the individual out-of-pocket coinsurance amount.**

Copay: There is a \$10 professional office call copay per-visit for services in the office, home, or hospital outpatient department. Copays do not apply toward the deductible.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan provider. Benefits will be based on the recognized provider's actual charge for the service.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers, only if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services or maternity admissions.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this or a prior plan with the Company (Regence BlueShield) for six consecutive months. There is a preexisting condition waiting period that must be met prior to benefits being available. Refer to your benefits brochure for details regarding this waiting period. Maternity benefits and PKU benefits are not subject to the waiting periods of this plan.

This is a brief summary of benefits, it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to your benefits brochure and the contract on file with your group. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.