

**ASSOCIATION OF WASHINGTON CITIES
SUMMARY OF BENEFITS
PLAN A Basic/Major Medical
\$50 Major Medical Deductible
Effective January 1, 2011**



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

For medically necessary services rendered by a participating or recognized 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 Major Medical benefits are subject to the \$50 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, and smoking cessation programs do not apply to the maximum out-of-pocket coinsurance amount.

The Company believes this coverage is a “grandfathered” health plan” under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in PPACA, for example, the elimination of lifetime limits on benefits.

Benefits	BASIC MEDICAL	MAJOR MEDICAL
Preventive Care Includes one Routine Gynecological exam and Pap Smear per year.	100%	100%
Dependent – Subject to deductible (Major Medical) <i>Mammograms, Prostate and Colorectal cancer screenings paid at the diagnostic x-ray and laboratory benefit under Basic for Sub/Dependent</i>		
Professional Services Including diagnostic x-ray and laboratory Dependent – Subject to Deductible (Major Medical)	100%	100%
Professional Services for Dependents for Accidental injury	100%	
Hospital Facility Inpatient and outpatient including diagnostic x-ray and laboratory No copay for emergency room visit	100%	
Acupuncture Limited to 12 visits per calendar year maximum	100%	
Ambulance Services *- subject to stoploss		80%
Blood Bank * - subject to stoploss	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)
Chemical Dependency	100%	
Growth Hormone	100%	
Home Health and Hospice Home health - 130 visits per calendar year maximum Hospice - 6 month maximum	100%	
Home Medical Equipment, Protheses and Orthotics		80%
Home Phototherapy – Dependent Only		100%
Hospitalization for Dental Services No annual benefit maximum	100%	
Maternity (provided for the subscriber, spouse or domestic partner) <i>(Special Beginnings Maternity Care Program 1-866-922-2911)</i>		Same as any other condition
Mental Disorder Inpatient/Outpatient – Subscriber and Dependent	100%	
(Referral recommended through AWC Employee Assistance Program)		

Benefits	BASIC MEDICAL	MAJOR MEDICAL
Neurodevelopmental Therapy No annual Benefit Maximum; Subject to Stoplos		80%
Occupational Injury No lifetime maximum	Same as any other condition	
Prescription Drug ** Limited to a 34-day supply, must use participating pharmacy		\$4 generic copay \$15 brand-name copay \$35 non-formulary copay Subject to 2 copays
Mail Order – Limited to a 90-day supply		
Rehabilitation Inpatient – Subscriber/Dependent	100%	To a maximum of 30 days
Outpatient – Subscriber/Dependent <i>Massage and Physical Therapy – Are covered when medically necessary when using a contracted provider (prescription required).</i>	100%	
Skilled Nursing Facility * Limited to 365 days per lifetime maximum	100%	
Smoking Cessation**	75%	
Spinal Manipulations Limited to 25 Spinal Manipulation per cal/year	100%	
Transplants Includes transplant donor; travel and lodging	100%	100%

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

** Benefits do not apply to the out-of-pocket coinsurance amount.

Lifetime Maximum: none

Annual Deductible: \$50 per person/\$150 per family

Annual Out-of-Pocket Coinsurance Amount: \$375 – 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: Not applicable at this time.

Emergency Care: 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 participating 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, whether or not a medical emergency, will be paid at the level specified for participating providers. Payment will be based on the allowed amount. Any balances of charges not covered by this plan will be your responsibility to pay. 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: Does not apply.

These benefit summaries provide a brief description of the health plan benefits, limitations and exclusions under the health care plan and is not a guarantee of payment. Benefits and other terms reflected on this summary are subject to future change in response to the Patient Protection and Affordable Care Act (PPACA) recently passed by the Congress and/or PPACA rules and other guidance from federal and state regulators.

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.