

Highlights of your Health Care Coverage

City of Spokane Police Relief and Pension Board - Effective January 1, 2008

MEDICAL PLAN	Your World – LEOFF I Police
MEDICAL COST SHARE OPTIONS	GLOBAL - ALL PROVIDERS+
Deductible PCY	\$0 PCY
Coinsurance	0%
Individual Out-of-Pocket Maximum PCY	Not Applicable
Office Visit Cost Share	0%
COVERED SERVICES	
PREVENTIVE CARE	
Preventive Office Visit (Unlimited)	Covered in Full
Immunizations (Unlimited)	Covered in Full
Health Education (\$250 PCY)	Covered in Full
Community Wellness, Prevention and Safety Programs (Shared with Health Education)	Covered in Full
Nicotine Dependency Programs (Shared with Health Education)	Covered in Full
Diabetes Education (Unlimited)	Covered in Full
PROFESSIONAL CARE	
Professional Office Visit Including Urgent Care	Covered in Full
Inpatient Professional Services	Covered in Full
Contraceptive Management (Unlimited)	Covered in Full
DIAGNOSTIC SERVICE OPTIONS	
Diagnostic Imaging & Laboratory Services	Covered in Full
Outpatient Mammography (Screenings and diagnostic)	Covered in Full
FACILITY CARE	
Inpatient Care	Covered in Full
Outpatient Surgery	Covered in Full
Skilled Nursing Facility (Unlimited)	Covered in Full
EMERGENCY CARE	
Outpatient Emergency	Covered in Full
Ambulance Transportation	Covered in Full
Air Ambulance (Unlimited)	Covered in Full
OTHER SERVICES	
Acupuncture (24 Visits PCY)	Covered in Full
Chemical Dependency Treatment (\$14,000 per 24 consecutive month period)	Covered in Full
Home Health Care (Unlimited)	Covered in Full
Hospice Care (Inpatient: Unlimited; Respite 240 hours; 6 month limit)	Covered in Full
Manipulations: Spinal and Other (24 Visits PCY)	Covered in Full
Medical Supplies, Equipment, Prosthetics (Unlimited). Orthotics (\$300 PCY)	Covered in Full
Mental Health Care (Inpatient and Outpatient: Unlimited)	Covered in Full
Orthognathic/Maxillofacial Care (\$5,000 Lifetime)	Covered in Full
Rehab Inpatient Facility (Unlimited)	Covered in Full
Rehabilitation (Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehabilitation and Chronic Pain) Inpatient: Unlimited. Outpatient: 45 Visits PCY	Covered in Full
Temporomandibular Joint (TMJ) Disorders (\$1,000 PCY; \$5000 per Lifetime Maximum)	Covered in Full
Transplants (Unlimited; No Waiting Period).	Covered in Full
SUPPLEMENTAL BENEFITS	
Routine Vision Exam (1 PCY)	Covered in Full
Vision Hardware (\$350 every 2 calendar years)	Covered in Full

PCY= Per Calendar Year

Revised: 01/21/08

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Lasik Eye Surgery (\$2,600 Lifetime Maximum)	Covered in Full
Hearing Exam (1 PCY)	Covered in Full
Hearing Hardware (\$3,200 Lifetime Maximum)	Covered in Full
LIFETIME MAXIMUM	Unlimited

+ Any coinsurance amounts based on a percentage of allowable charges. You may be responsible for additional charges if a provider is not contracted with Premera Blue Cross.

Pharmacy benefits

Below is a brief overview of what you can expect to pay for a prescription drug. For more information on your pharmacy benefits, including Non-Participating Retail Pharmacies, see your benefit booklet.

PHARMACY PLAN	
OUTPATIENT PRESCRIPTION DRUGS	Cost Share
Retail Pharmacy (Includes medically necessary Over-the-Counter Drugs purchased at a participating pharmacy and prescribed by a physician)	0% Dispensing Limit Up to a 365-day supply or 365 unit supply of covered medication unless the drug maker's packaging limits the supply in some other way.
Mail Order	\$0 Copay Up to 90 day supply per prescription
Out-of-Network Nonparticipating retail pharmacies	\$0
Out-of-Pocket Maximum	Unlimited
Annual Benefit Maximum	Unlimited

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.