

Highlights of your Health Care Coverage

City of Spokane – Effective January 1, 2009

MEDICAL PLAN	Your Choice – City Plan III - \$10 / \$20 Rx	
MEDICAL COST SHARE OPTIONS	HERITAGE IN-NETWORK+ SE IN-NETWORK	HERITAGE OUT-OF-NETWORK+
Deductible PCY (Individual/Family)	\$100 / \$300	Shared with In Network Deductible
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Out-of-Pocket Maximum PCY (Excludes Deductible)	\$625 Individual / \$1,875 Family	Not Applicable
Office Visit Cost Share	Waive Deductible on first 3 OV covered in full for illness or injury	Deductible/Coinsurance
COVERED SERVICES *		
PREVENTIVE CARE **		
Preventive Care Office Visit (Unlimited)	Waive Deductible then 20%	Not Covered
Immunizations (Shared with Preventive Limit)	Waive Deductible then 20%	Not Covered
Health Education (\$250 PCY)	Covered In Full**	Not Covered
Community Wellness, Prevention and Safety Programs (CW) (\$250 PCY)	Covered In Full**	Not Covered
Nicotine Dependency Programs (Shared with Community Wellness)	Covered In Full**	Not Covered
Diabetes Education (Unlimited)	Covered in Full**	Not Covered
PROFESSIONAL CARE		
Professional Office Visit including Urgent Care	First three visits for illness or injury (excluding office surgery) covered at 100%** Deductible and coinsurance thereafter	40%
Inpatient Professional Services	20%	40%
Contraceptive Management (Unlimited)	First three visits for illness or injury (excluding office surgery) covered at 100%** Deductible and coinsurance thereafter	40%
DIAGNOSTIC SERVICE OPTIONS		
Diagnostic Imaging and Laboratory Services	First \$100 Covered in Full** Deductible and Coinsurance thereafter	40%
Mammography (Screenings and Diagnostic)	20%	40%
FACILITY CARE		
Inpatient Facility	20%	40%
Outpatient Surgery Facility	20%	40%
Skilled Nursing Facility (180 days)	20%	40%
EMERGENCY CARE		
Outpatient Emergency Care (Deductible and coinsurance apply)	20%	
Ambulance Transportation	20%	
Air Ambulance	20%	
OTHER SERVICES		
Acupuncture (24 visits PCY)	20%	40%
Chemical Dependency Treatment (\$14,500 max per 24 mo)	Outpatient: 20% Inpatient: 20%	40%
Home Health Care (130 home health agency visits PCY)	Deductible then Covered in Full	40%
Hospice Care (6 months max; Inpatient: Unlimited; Respite: 240 hrs max)	Deductible then Covered in Full	40%
Manipulations: Spinal and Other (30 visits PCY)	20%	40%
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Supplies: Unlimited; Equipment: Unlimited, Prosthetics: Unlimited. Orthotics \$300 PCY)	20%	40%
Mental Health Care*** (Outpatient 30 visits PCY; Inpatient 10 days PCY)	Outpatient: 20% Inpatient: 20%	40%

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	HERITAGE IN-NETWORK+	HERITAGE OUT-OF-NETWORK+
Naturopathic Services (Unlimited)	20%	40%
Orthognathic/Maxillofacial Care (\$1,000 Lifetime)	Covered as Any Other Service	40%
Rehabilitation*** (Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehabilitation) Outpatient: 45 Visits, Inpatient: 30 Days	Outpatient: 20% Inpatient: 20%	40%
Temporomandibular Joint (TMJ) Disorders (\$1,000 PCY; \$5,000 per Lifetime Maximum)	Deductible then Covered in Full	40%
Transplants (6 month waiting period; \$250,000 Combined Inpatient & Outpatient per Lifetime maximum)	Outpatient: First three visits for illness or injury (excluding office surgery) covered at 100%**. Deductible & Coinsurance thereafter. Inpatient: 20%	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam and Testing (1 PCY)	Waive Deductible, Covered In Full	Deductible/Coinsurance
Routine Vision Hardware (\$200 every 2 years)	Covered in Full	Covered in Full
LIFETIME MAXIMUM	\$2,000,000	

(Note: Copays, deductibles and coinsurance percentages reflect **the member's cost share**)

*Benefits listed apply after calendar year deductible is met, unless otherwise specified.

Deductible waived * Excluded from Out-of-Pocket Maximum. PCY = Per Calendar Year

+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 Blue Shield.

Pharmacy Benefit	Tier 1= Generic
	Tier 2 = Brand
Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-Of-Network benefits, see your benefit booklet.	
PHARMACY PLAN	\$10 / \$20 Retail
OUTPATIENT PRESCRIPTION DRUGS	Cost Share Options Tier 1 / Tier 2
Retail Pharmacy Copays	\$10 Generic / \$20 Brand Maximum supply: 30-day or 100-unit supply, whichever is greater, unless the drug maker's packaging limits the supply in some other way.
Deductible	None
Out Of Network Nonparticipating retail pharmacies	Applicable Tier Cost Share, then 40%
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.