



## WBACC PPO FOURFRONT \$200

Preferred Plan FourFront has the following unique features: 1) The first four office, home, or outpatient hospital visits per year and the first \$500 per year for outpatient diagnostic x-ray and laboratory services will not be subject to the annual deductible and will be provided as specified below; 2) Fifth and subsequent office, home or outpatient hospital visits, outpatient diagnostic x-ray and laboratory exceeding the first \$500 per year, and all other professional services not billed as an office visit will be subject to the annual deductible and will be provided as specified below; and 3) Preventive care benefits are covered to a \$300 annual maximum and not subject to deductible. Refer to the Benefit Booklet for limitations that may apply. All other benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. All benefits must be medically necessary and are subject to any copays and coinsurance unless otherwise specified. 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, unless otherwise specified.

<b>Deductible</b>	\$200 Individual/\$600 Family
<b>Out of Pocket Maximum</b>	\$2,500 Individual/\$7,500
<b>Rx</b>	\$10/20/40, Mail Order - 90 Days \$20/40/80
<b>Lifetime Maximum</b>	\$2,000,000 - \$20,000 annual reinstatement

<b>Benefits</b>	<b>Preferred Providers*</b>	<b>Participating Providers</b>
<b>Professional</b> <b>Not subject to deductible</b> First 4 office, home, or outpatient hospital visits per year after office-visit copay and first \$500/year for outpatient x-ray and lab  <b>Subject to deductible</b> Fifth and subsequent office, home, or outpatient hospital visits per year after office-visit copay; outpatient x-ray and lab above the first \$500/year; and other professional services not billed as an office visit	100%, \$25 copay	50%
<b>Hospital Services</b> \$75 ER copay waived if admitted	80%	50%
<b>Maternity</b> Not subject to preexisting condition waiting period	80%	50%
<b>Skilled Nursing Facility</b> 90 days per calendar year	Only Participating providers currently available	80%
<b>Ambulance</b>	80% Recognized Ambulance Providers Only	
<b>Inpatient Rehab Services</b> \$30,000 maximum per condition	80%	50%
<b>Outpatient Rehab</b> \$1,500 maximum per calendar year	80%	50%
<b>Inpatient Mental Health</b> 8 days per calendar year	80%	50%
<b>Outpatient Mental Health</b> 12 visits per calendar year	80%	50%
<b>Spinal Manipulations</b> 10 spinal manipulations per calendar year	80%	50%
<b>Chemical Dependency</b> \$13,500 maximum every two calendar years	80%	50%
<b>Transplants</b> 6 month waiting period, \$250,000 lifetime maximum, \$50,000 per transplant organ procurement, \$2,500 per transplant travel and lodging maximum	80%	50%
<b>Smoking Cessation</b> \$500 lifetime maximum	75%	75%

\*To determine if a provider is "Preferred", refer to the Regence BlueShield provider directory or the website [www.wa.regence.com](http://www.wa.regence.com). You may also call one of the WBACC Member Service Specialists at Regence BlueShield. This plan is underwritten by Regence BlueShield of Seattle, WA., an Independent Licensee of the BlueShield Association. This is a brief summary of benefits. For full coverage provisions, including a description of waiting periods, limitations and exclusions, refer to your benefits brochure.