

# Health Plan Summary

## Deputy Sheriffs



### Medical/Vision

The following table summarizes the features and covered expenses of the three medical plan options. Vision coverage is provided as a medical plan benefit.

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Provider choice	You must use Regence BlueShield and recognized providers for all covered services received within the service area (except emergency care) and may use any approved provider for covered services outside the service area	You choose a PacifiCare primary care physician (PCP) who provides and coordinates services through the PacifiCare network; no non-network coverage unless indicated	You choose a Group Health primary care physician (PCP) who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	\$100 per person/\$300 per family	None (unless you live outside the PacifiCare service area)	None
Copay/office visit	None	\$5	\$7
After the deductible/copays, the plans pay most covered services at these levels until you reach the annual out-of-pocket maximum	80%-100% of the allowed amount	100% network	100% network
Annual out-of-pocket maximum	\$375/person (excluding deductible and copays)	\$500/person, \$1,500/family for network care and limited emergency/out-of-area care	\$1,000/person, \$2,000/family for network care and limited emergency/out-of-area care
After you reach the out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	100%	100%	100%
Lifetime maximum	\$1,000,000	No limit	No limit
Alternative care	100% up to 12 visits/year to approved provider for acupuncture	100% after \$5 copay/visit when referred by PCP	Self-referrals to a network provider are covered up to 8 visits/medical diagnosis/calendar year for acupuncture and up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services, all other alternative care may require PCP referral \$20 copay/visit

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Ambulance services	80%	100%	80% (except hospital-to-hospital ground transfers covered 100% when initiated by Group Health)
Chemical dependency treatment	100% inpatient/outpatient Up to \$12,500 (2005)/\$13,000 (2006) maximum/2 years (maximum subject to annual adjustment)	100% for inpatient/outpatient \$12,500 (2005)/\$15,000 (2006) maximum/24 consecutive calendar months (maximum subject to annual adjustment)	100% for inpatient 100% after \$7 copay/visit for outpatient \$12,500 (2005)/\$13,000 (2006) maximum/24 consecutive months (maximum subject to annual adjustment)
Chiropractic care	100%	100% after \$5 copay when referred by PCP 100% after \$10 copay/visit up to 33 visits/year when self-referred (must see a network provider)	100% after \$7 copay/visit
Diabetes care training	80%	100%	100% after \$7 copay/visit
Durable medical equipment and diabetic equipment	80%	100%	80%
Emergency care (in an emergency room)	80% after \$25 copay/visit (waived if admitted)	100% after \$50 copay/visit (waived if admitted)	100% after \$75 copay/visit to network facility (copay waived if admitted) 100% after \$125 copay/visit to non-network facility (copay waived if admitted)
Family planning	Covered at various levels; call plan for details	100%	Covered at various levels; call plan for details
Home health	90% up to 130 visits/year	100% up to 130 visits/year	100%
Hospice care	90% (6-month maximum with up to 14 days inpatient care)	100% (6-month lifetime maximum)	100% (limits apply; call plan for details)
Hospital care	80%	100%	100%
Injury to teeth	80% dentist/denturist services up to \$1,000/injury	100%	Not covered
Lab, x-rays and other diagnostic testing	100% professional services; 80% hospital/facility services	100%	100%
Maternity care - delivery and related hospital care	100% professional services; 80% hospital/facility services	100%	100%
Maternity care - prenatal and postpartum care	100% professional services; 80% hospital/facility services	100% after \$10 copay/pregnancy	100% after \$7 copay/visit
Mental health care	100% professional services and 80% hospital/facility services for inpatient up to 8 days/year 100% for outpatient up to 12 visits/year	100% for inpatient up to 30 days/year; 100% residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) 100% after \$5 copay/visit up to 30 visits/year	100% for inpatient up to 12 days/year 100% after \$7 copay/individual, family or couple/visit or \$7 copay/group session for outpatient up to 20 visits/year

Plan Feature	Regence BlueShield	PacifiCare	Group Health
<b>Neurodevelopmental therapy for covered family members age 6 and under</b>	80% up to \$2,000 annual benefit maximum	100% for inpatient 100% after \$10 copay/visit for outpatient up to 60 visits/year when referred by PCP and preauthorized	100% for inpatient up to 60 days/year (combined with rehabilitative services) 100% after \$7 copay/visit for outpatient up to 60 visits/year (combined with rehabilitative services)
<b>Newborn care</b> (up to at least 3 weeks as mandated by state law)	100% professional services; 80% hospital/facility services	Covered at various levels; call plan for details	Covered at various levels; call plan for details
<b>Physician and other medical and surgical services</b>	100% in an office, home, hospital or skilled nursing facility and for surgery	100% for inpatient 100% for outpatient after \$5 copay/visit	100% for inpatient 100% after \$7 copay/visit for outpatient
<b>Phenylketonuria (PKU) formula</b>	100%	100%	100%
<b>Prescription drugs - network pharmacies</b> (including insulin and diabetic supplies)	Up to 34-day supply 100% after \$7 copay for generic 100% after \$12 copay for brand-name 100% after \$27 for non-formulary	Up to 30-day supply 100% after \$5 copay for generic (brand-name drugs are covered only when generic not available)	Up to 30-day supply 100% after \$5 copay
<b>Prescription drugs - mail order</b> (including insulin and diabetic supplies)	Up to 90-day supply 100% after \$14 copay for generic 100% after \$24 copay for brand-name 100% after \$54 copay for non-formulary	Up to 90-day supply 100% after \$10 copay for generic (brand-name drugs are covered only when generic not available)	Up to 30-day supply 100% after \$5 copay
<b>Preventive care</b> (such as routine exams and immunizations)	100%	100% after \$5 copay/visit	100% after \$7 copay/visit (according to well-child/adult preventive care schedule)
<b>Radiation therapy and chemotherapy</b>	100% professional services; 80% hospital/facility services	100%	100% after \$7 copay/visit
<b>Reconstructive services</b> (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy, including lymphedema; call plans for more information)	100% professional services; 80% hospital/facility services	100% depending on services provided; copays may apply	100% for inpatient 100% after \$7 copay/visit for outpatient

Plan Feature	Regence BlueShield	PacifiCare	Group Health
<b>Rehabilitative services</b>	100% professional and hospital/facility services for inpatient up to \$50,000/condition 80% for outpatient up to \$2,000/year	100% for inpatient 100% after \$10 copay/visit for outpatient up to 60 visits/year when referred by PCP and preauthorized	100%for inpatient up to 60 days/year (combined with neurodevelopmental therapy) 100% after \$7 copay/visit for outpatient up to 60 visits/year (combined with neurodevelopmental therapy)
<b>Skilled nursing facility</b>	80% up to 90 days/year when preauthorized	100% up to 150 days lifetime maximum/condition (must be instead of a hospital stay) when referred by PCP and preauthorized	100% up to 60 days/condition at Group Health-approved nursing facility
<b>Smoking cessation</b>	75% up to \$500 lifetime maximum for approved program	100% after \$20 copay/network program 100% after \$20 copay for each 4-week supply of nicotine replacement if prescribed by PCP (90-day treatment maximum)	100% network provider program 1 course of nicotine replacement/year (prescription copay applies) when prescribed by network provider
<b>Sterilization procedures</b>	100% professional services; 80% hospital/facility services	100%	100% after \$7 copay/visit for outpatient
<b>Temporomandibular joint (TMJ) disorders</b>	Not covered	Not covered	100% for inpatient 100% after \$7 copay/visit for outpatient Up to \$1,000/year and \$5,000 lifetime maximum
<b>Transplants (certain transplants/services only)</b>	100% professional; 80% hospital/facility services and travel expenses Donor organ procurement costs up to \$50,000/transplant; travel expenses up to \$2,500/transplant \$250,000 lifetime maximum	100% up to \$500,000 lifetime maximum Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or emergency	Covered subject to applicable copay; limits and exclusions apply; call plan for details Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or emergency
<b>Urgent care</b>	Covered at various levels; call plan for details	100% after \$5 copay/visit	100% after \$7 copay/visit at network facility
<b>Vision care – routine exams</b>	100% for 1 exam/calendar year Deductible doesn't apply	100% for 1 exam every 12 months from network provider (Cole Vision Service) 100% up to \$40 for 1 exam every 12 months from non-network provider	100% after \$7 copay for 1 exam in 12 consecutive months (must use Group Health providers)
<b>Vision care - lenses</b>	Up to 2 lenses/calendar year \$20/single vision lens \$30/bifocal lens \$40/trifocal lens \$65/lenticular or aphakic lens (external lens requiring a frame)	100% for 1 pair of lenses every 12 months from network provider (Cole Vision Service) 100% up to \$100 for 1 pair of lenses every 12 months from non-network provider	Not covered

Plan Feature	Regence BlueShield	PacifiCare	Group Health
Vision care - frames	\$30 for 1 pair of frames/2 calendar years beginning with the initial date of service Deductible doesn't apply	100% up to \$150 retail value for 1 pair of frames every 24 months from network provider (Cole Vision Service) 100% up to \$100 for 1 pair of frames every 24 months from non-network provider	Not covered
Vision care - contact lenses (instead of glasses)	If medically necessary, up to \$100/lens for aphakia or for vision correctable to 20/70 or better only by use of contact lenses If cosmetic/elected, up to \$20/lens Deductible doesn't apply	100% up to \$150 retail value for 1 pair of contacts every 24 months from network provider (Cole Vision Service) 100% up to \$100 for 1 pair of contacts every 24 months from non-network provider	Not covered

## Dental

Dental coverage is provided by Washington Dental Service. You can use any dentist you wish, but the benefits are generally higher (your out-of-pocket expenses are less) and the dentist automatically files your claim if you see a WDS dentist (most dentists in Washington participate in the WDS plan).

WDS increases your payment levels through an incentive program as long as you see your dentist each year. For diagnostic and preventive services as well as basic and restorative services, the payment level starts at 70% and increases 10% in January of each year until you reach 100% (if you don't see the dentist during the calendar year your payment level is reduced to the next lower payment level, but never below 70%).

If you're a new hire, coverage begins at the 70% incentive level; levels "earned" under another group plan don't apply to the county plan. However, incentive levels are adjusted based on previous participation in the county plan if you're a:

- Recalled or reinstated employee
- Rehired employee who's continued county coverage uninterrupted under COBRA between your previous county employment and rehire (if county coverage has been interrupted, new hire incentive levels apply).

<b>Washington Dental Service</b>	
<b>Annual deductible</b>	None
<b>Annual maximum benefit</b> (doesn't apply to orthodontic or orthognathic services)	\$2,500/person
<b>Covered Expenses</b>	<b>Plan Pays</b>
<b>Diagnostic and preventive services</b> (1 exam and cleaning every 6 months, complete x-rays every 3 years, supplemental bitewing x-rays every 6 months)	70%-100% based on your incentive level; see dental booklet for details
<b>Basic services</b> (extractions, fillings, periodontics, root canals, stainless steel crowns)	70%-100% based on your incentive level; see dental booklet for details
<b>Major services – restorative</b> (crowns, fixed bridges, onlays)	70%-100% based on your incentive level; see dental booklet for details
<b>Major services – prosthodontics</b> (for example, dentures)	70% (incentive levels don't apply)
<b>Orthodontic services - adults and children</b>	60%, up to a \$2,500 lifetime benefit maximum (incentive levels don't apply; benefit doesn't apply to the annual maximum benefit)
<b>Orthognathic surgery</b>	70% up to a \$5,000 lifetime maximum benefit
<b>Accidental injury</b>	100% for covered expenses incurred within 180 days of accident