


Spokane Regional Health District

Comparison of Medical Benefits and Rates - Effective January 1, 2010

	GROUP HEALTH Options POS Current/Renewal		GROUP HEALTH Options POS (RQ-23354)	
	Core	Buy-up	Core	Buy-up
<i>Cost Share Options</i>	In Network (GH Provider)	Out of Network (First Choice Network) (1)		
In-Network Annual Deductible	\$500 per Member /\$1,500 Family		\$1,000 per Member/ \$3,000 Family	\$500 per Member / \$1,500 Family
Out-of-Network Deductible	Shared with In-Network Deductible		Shared with In-Network Deductible	Shared with In-Network Deductible
Fourth Quarter Carry Over	Included		Not Included	Not Included
Out-of-Pocket Per Year (Including deductible)	\$3,500 Member / \$10,500 Family	Shared with In Network	\$4,000 per Member / \$12,000 Family	\$3,500 per Member / \$10,500 Family
Coinsurance (most services)	80/20%		80/20%	80/20%
Coinsurance Out-of-Network (most services)	70/30%		60/40%	70/30%
Lifetime Maximum	\$2,000,000		\$2,000,000	\$2,000,000
	In Network (GH Provider)	Out of Network (First Choice Network) (1)	* First 4 Office Visits per year @ copay, thereafter, deductible, coinsurance and copay apply.	
Office Visit	\$20 Copay	\$20 Copay	* \$25 Copay	\$25 Copay
Office Visit Procedures	\$20 Copay	\$20 Copay	\$25 Copay, Deductible + Coinsurance	\$25 Copay
Diagnostic X-Ray & Lab				
Inpatient	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient	Paid in full when in conjunction with an office visit	Paid in full when in conjunction with an office visit	First \$500 covered in full, then Ded + Coins	Paid in full when in conjunction with an office visit
Preventive Care	\$20 Copay	\$20 Copay	\$25 Copay (deductible and coinsurance waived)	\$25 Copay
Hospital Services	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Emergency Room	\$75 Copay + Ded + Coins	\$125 Copay + Ded + Coins	\$150 Copay + Deductible + Coinsurance	\$150 Copay + Ded + Coins
<i>Other Services</i>				
Chiropractic	\$20 Copay, 10 visits PCY	\$20 Copay, 10 visits PCY	\$25 Copay, deductible and coinsurance, 10 visits PCY	\$25 Copay, 10 visits PCY
Mental Health				
Inpatient	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance	Deductible + Coinsurance
Outpatient	\$20 Copay	\$20 Copay	\$25 Copay + Deductible + Coinsurance	\$25 Copay
Rehabilitation				
Inpatient	Ded + Coins, 60 days PCY	Ded + Coins, 60 days PCY	Ded + Coins, 60 days PCY	Ded + Coins, 60 days PCY
Outpatient	\$20 Copay, 60 visits PCY	\$20 Copay, 60 visits PCY	\$25 Copay, deductible + coinsurance, 60 visits PCY	\$25 Copay, 60 visits PCY
Durable Medical Equipment	80/20 Coins up to \$5,000 (\$4,000 DME) \$32,000 (Prosthetics) benefit	Benefits and limits shared with in-network	80/20 Coins up to \$5,000 (\$4,000 DME) \$32,000 (Prosthetics) benefit	80/20 Coins up to \$5,000 (\$4,000 DME) \$32,000 (Prosthetics) benefit
TMJ (Inpatient)	Ded + Coins, \$1,000 PCY, \$5,000 Lifetime	Ded + Coins, \$1,000 PCY, \$5,000 Lifetime	Ded + Coins, \$1,000 PCY, \$5,000 Lifetime	Ded + Coins, \$1,000 PCY, \$5,000 Lifetime
Vision Exam & Hardware	\$20 Copay Exam every 12 mos \$200 Hardware per 24 mos	\$20 Copay Exam every 12 mos \$200 Hardware per 24 mos	\$25 Copay Exam every 12 mos \$200 Hardware per 24 mos	\$25 Copay Exam every 12 mos, \$200 Hardware per 24 mos
<i>RX Benefits</i>				
Pharmacy (30-day supply)				
Generic/Preferred Brand/Non-Preferred Brand	\$5/\$20/\$35	\$10/\$25/\$40	\$5/\$20/\$35	\$5/\$20/\$35
Mail Order (90-day supply)				
Generic/Preferred Brand/Non-Preferred Brand	\$10/\$40/\$70	No out of Network mail order	\$10/\$40/\$70	\$10/\$40/\$70
<i>Rates:</i>				
	Current	Renewal	Core	Buy-Up
Employee	\$667.00	\$869.00	\$703.00	\$832.00
Employee/Spouse	\$787.00	\$1,025.00	\$829.00	\$982.00
Employee/Spouse/Child(ren)	\$948.00	\$1,235.00	\$999.00	\$1,182.00
Employee/Child(ren)	\$668.00	\$870.00	\$704.00	\$833.00

This is a brief comparison only. For more detailed information, please see carrier proposals. If any discrepancies exist, the contract shall prevail.

(1) When receiving care outside of the Group Health Network you will be subject to out of network benefits. If you see a physician in the First Choice Network members will not be subject to balance billing. If you see a physician outside of the Group Health Network and outside of the First Choice Network, balance billing may apply.

Proposal Spokane Regional Health District

Effective Date 1/1/2010 thru 1/1/2011



	Core Options		Buy-Up 1 Options	
	Inside Network	Outside Network	Inside Network	Outside Network
Group Name	Spokane Regional Health District		Spokane Regional Health District	
Group Number	8002900		0000000	
Type of Offering	Sole Carrier		Sole Carrier	
Deductible (I/F)	\$1000/3x		\$500/3x	
Coinsurance	80/20%	60/40%	80/20%	70/30%
Ded/Coins waiver riders	1st 4 visits not subject to ded/coins, lab/xray paid in full up to first \$500		Deductible and coinsurance do not apply to outpatient services	
OOP Max (I/F)	\$3000/3x		\$3000/3x	
Lifetime Max	\$2 million		\$2 million	
IP Hospital	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Outpatient Svcs	\$25 copay, ded/coins	\$25 copay, Ded/Coins	\$25 copay, ded/coins waived	
ER (designated/non-des facility)	\$150 copay Ded/Coins	\$200 copay Ded/Coins	\$150 copay Ded/Coins	\$200 copay Ded/Coins
Lab/X-ray	Ded/coins 100% for 1st \$500		Ded/coins	Ded/Coins
Pharmacy - 30 day supply	Generic/Brand/non-Formulary \$5/\$20/\$35 copay		Generic/Brand/non-Formulary \$5/\$20/\$35 copay	
Optical Hardware	RX-NA		RX-NA	
Optical Hardware	\$200 per 24 months, ded/coins waived		\$200 per 24 months, ded/coins waived	
Rates by Tier	RQ-23354		RQ-23354	
	EE	\$ 703.00	EE	\$ 832.00
	EE/S	\$ 829.00	EE/S	\$ 982.00
	EE/C	\$ 704.00	EE/C	\$ 833.00
	EE/S/C	\$ 999.00	EE/S/C	\$ 1,182.00
Commission	Included		Included	

Benefit Summary
 Spokane Regional Health District Welcome Plan
 Group Number: 8002900



Effective Date 1/1/2010 **Health Plan Options - Core** **Ref** RQ-23354

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network	Outside Network
Plan deductible (PCY) - per calendar year	Individual deductible: \$1000 Family deductible: \$3000	Shared with in-network
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40%
Deductible and/or coinsurance waiver riders	1st 4 visits not subject to ded/coins, lab/xray paid in full up to first \$500	Same as in-network
Pre-existing condition (PEC) waiting period	3 Months	Same as in-network
Out-of-pocket limit	Individual out-of-pocket limit: \$3000 Family out-of-pocket limit: \$9000	Shared with in-network
Lifetime Maximum	\$2 million	Shared with in-network maximum
Outpatient Services (Office visits - OV)	\$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$25 copay, deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$25 copay, deductible and coinsurance apply
Prescription drugs	Formulary generic/formulary brand/non-formulary \$5/\$20/\$35 copay	Formulary generic/formulary brand/non-formulary \$10/\$25/\$40 copay
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
Ambulance Services	80/20% coinsurance	Same as in-network
Chemical Dependency	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Devices, equipment and supplies (DME prosthetics)	20% coinsurance up to \$5,000 (\$4,000 max. benefit for DME, \$32,000 max. benefit for Prosthetics)	Benefits and limits shared with in-network
Diagnostic lab and X-ray Services (outpatient)	Deductible and coinsurance apply (Paid in full up to the first \$500)	Deductible and coinsurance apply (Paid in full up to the first \$500, shared with in-network)
Emergency Services (copay waived if admitted)	\$150 copay Deductible and coinsurance apply	\$200 copay Deductible and coinsurance apply
Growth hormone	Covered at pharmacy cost share; no wait	Covered at pharmacy cost share; no wait
Hearing exams (Routine)	\$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Self-referred up to 10 visits PCY \$25 copay, deductible and coinsurance apply	10 visit limit PCY \$25 copay, deductible and coinsurance apply
Maternity services	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Mental Health	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply

Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Not covered	Not covered
Organ transplants Donor search & harvest rolls to lifetime max	\$350,000 lifetime max; includes donor search & harvest of \$50,000; 6 month wait, time credit available Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Benefit limit shared with in-network Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	\$25 copay (deductible and coinsurance waived)	\$25 copay (deductible and coinsurance waived)
Rehabilitation services (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	Outpatient: 60 visits PCY \$25 copay, deductible and coinsurance apply Inpatient: 60 days PCY Deductible and coinsurance apply	Outpatient: Visit limits shared with in-network \$25 copay, deductible and coinsurance apply Inpatient: Day limits shared with in-network Deductible and coinsurance apply
Skilled nursing facility (PCY)	Up to 60 days, deductible and coinsurance apply	Days shared with in-network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	\$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) Services	\$1,000 PCY; \$5,000 lifetime max Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply	Shared with in-network Outpatient: \$25 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Tobacco Cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not covered
Vision care Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	\$25 copay, deductible and coinsurance waived	\$25 copay, deductible and coinsurance apply
Optical Hardware Lenses, including contact lenses, and frames	\$200 per 24 months Not subject to deductible and coinsurance	Shared with in-network



Effective Date 1/1/2010**Health Plan** Options -Buy-Up**Ref** RQ-23354

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