

**San Juan County
Benefit Comparison**

<u>Medical and Vision Plan</u>	Current Regence Blue Shield Network	New Plan Group Health Options Network
Benefit Outline		
Annual Summary		
Deductible ¹ (<i>in-network/out-of-network</i>)	\$300 (family x3)	\$500 (family under review)
Out-of-pocket Maximum (<i>in-network/out-of-network</i>) <i>Includes deductible</i>	\$2,500 (family x3)	\$2,000 (family under review)
Coinsurance	No	No
Preferred / In-Network	80%	90%
Participating / Extended Network	50%	80%
Non-Participating / Out-of-Network	Not Covered	80%
Benefit Maximum	\$2,000,000	\$2,000,000
Member Copays and Coinsurance		
Office Visit Copay; Coinsurance		
Preferred / In-Network	80%	90%
Participating / Extended Network	50%	80%
Non-Participating / Out-of-Network	Not Covered	80%
Preventive Care Copay; Coinsurance		
Preferred / In-Network	80%; (dw) ²	100%; (dw)
Participating / Extended Network	50%; (dw)	100%; (dw)
Non-Participating / Out-of-Network	Not Covered	100%; (dw)
<i>Preventive Care Annual Limit</i>	No Limit	No Limit
Laboratory and X-ray	80% / 50%	90% / 80%
Prescription Drug Copay		
Preferred / In-Network	\$10/\$20/\$40	\$10/\$20
Participating / Extended Network	\$10/\$20/\$40	\$15/\$25
Non-Participating / Out-of-Network	Not Covered	\$15/\$25
Spinal Manipulations	Covered as any other service	Covered as any other service
Spinal Visit Annual Maximum	Unlimited	Unlimited
Emergency Room Copay	\$75	\$75 / \$125
Outpatient Mental Health	Covered as any other service	Covered as any other service
Outpatient Mental Health Day Limit	12 visits	Unlimited
Inpatient Mental Health	Covered as any other service	Covered as any other service
Inpatient Mental Health Visit Limit	8 days	Unlimited
Vision Exam ³		
Preferred / In-Network	100%; (dw)	100%; (dw)
Participating / Extended Network	100%; (dw)	80%
Non-Participating / Out-of-Network	Not Covered	80%
Vision Hardware ³	80% to \$200 every 2 calendar years (dw)	100% to \$200 every 24 months (dw)

<u>Dental Plan</u>	Current Regence-Trad Plan 11 Network	New Plan WDS Network
Benefit Outline		
Annual Summary		
Deductible ² (<i>individual/family</i>)		
Preferred / In-Network	\$25 / \$75	\$0
Participating / Extended Network	\$25 / \$75	\$50/\$150
Non-Participating / Out-of-Network	\$25 / \$75	\$50/\$150
Member Coinsurance		
Preventive	100%; (dw)	100%; (dw)
Basic Services	80%	80%
Major Services	50%	50%
Annual Maximum	\$2,000	\$2,000
Additional Benefits		
Orthodontia	Not Covered	Not Covered
Implants	50%	50%
TMJ	\$1,000 PCY; \$5,000 Lifetime	\$1,000 PCY; \$5,000 Lifetime

Notes and Assumptions

1. Unless stated otherwise, deductible applies.
2. dw = deductible waived
3. Vision coverage on Regence plans is for Employee Only.