Medical Insurance Comparison Chart

This comparison chart summarizes plans available to members of the Corrections Guild

(Effective 4/1/2020 – 3/31/2021 | Category F | COBRA Division 2)

Summary of Benefits	Regence BlueShield Select 17 PPO			Kaiser Permanente Core HMO[7]
	Preferred	Participating	Non-participating	In-Network
Deductible[1] Individual Family	$0 $0		$200 $600	None
Out-of-Pocket Maximum[1] Individual Family	$2,500 $7,500		$10,200 $30,600	$1,000 $2,000
Preventive Care Visit	No charge		30%	No charge
Office Visit	$17	$17 + 30%	30%	$20
Ambulance	20%			20%
Durable Medical Equipment	No charge	30%		No charge
Emergency Room Services[4]	$75			$75[7]
Hospital Care (inpatient)	No charge	30%		No charge/$20 (outpatient)
Mental Health (outpatient)	$17		30%	$20
Outpatient Surgery	No charge	30%		$20
Prescription Drugs[5,6] Generic Preferred Brand Non-preferred Brand	$10/$20 $20/$40 $30/$60			$15/$30 $15/$30 Not covered
Radiology & Laboratory	No charge	30%		No charge
Rehabilitation[3] (outpatient)	$17	$17 + 30%	30%	$20
Spinal Manipulations[3]	$17	$17 + 30%	30%	$20

1. Deductible: The amount you pay per calendar year before the plan begins to pay
2. Out-of-Pocket Maximum: The most you could pay per calendar year for your share of covered services
3. Coverage is limited to certain number of visits per calendar year
4. Copay is waived if you are admitted to the hospital
5. First amount listed is the retail copay for a 30 day supply; second amount listed is the mail order copay for a 90 day supply
6. No charge for FDA approved women's contraceptives prescribed by a health care provider and certain preventive drugs and immunizations at a participating pharmacy. No charge for certain tobacco use cessation drugs when obtained with a prescription order at a participating pharmacy.
7. Must use in-network providers, except for emergency services and care pursuant to a referral/pre-authorization

This comparison chart is not an all-inclusive list of benefits, and should not be considered a replacement for the more detailed information set forth in the plan booklets produced by each insurance company. All covered benefits are subject to the limitations, exclusions and provisions of the plan. To be covered, medical services and supplies must be medically necessary for the treatment of an illness or injury (except for any covered preventive care).

All dollar amounts provided indicate a copay you are responsible for paying after you have met your annual deductible, if applicable. All percentages provided indicate your share for covered services after you have met your annual deductible, if applicable. If there are any discrepancies between this summary and the official plan booklets, the plan booklets will govern in all cases. Plan booklets, Summary of Benefits and Coverage (SBC) documents, and monthly premiums are online at www.snohomishcountywa.gov/983/Medical. Call Regence BlueShield at 800-962-0301 or Kaiser Permanente at 888-901-4636 for assistance with specific benefit/coverage questions.