Medical Provider Comparison

<u>Service</u>	City of Redmond Health Benefit Plan (RedMed)	Group Health Cooperative (GHC)
Providers	Option of receiving care from "Regence Preferred Provider" or provider of your choice.	Generally limited to seeing GHC providers.
Annual Deductible	\$100 per individual or \$300 per family.	No deductible.
Maximum Annual Out-of-pocket Expense	\$600/individual; \$1,200/family.	\$2,000/individual; \$4,000/family
Premiums	No cost for full-time employees; pro-rated for part-time employees. Premium cost-sharing for dependents. See rate sheets.	Employees who elect to be covered by Group Health shall pay the cost of such coverage that exceeds the amount paid by the City under the Red-Med plan. Rates are pro-rated for part-time employees. Premium cost-sharing for dependents. See rate sheets.
Physician Services	80% of covered expenses.	\$10 co-payment.
Prescription Drugs	80% at retail pharmacy; or co-pay for mail-order prescription (minimum 90 day supply).	\$10 co-payment.
Hospital Services	80% of covered expenses.	Covered in full. No day or dollar limit.
Laboratory & X-ray Services	80% of covered expenses.	Covered in full.
Maternity Care	Paid as any medical condition.	Covered in full.
Maternity Hospital Stay	80% of covered expenses.	Subject to inpatient services co-payment.
Emergency Care	\$50 co-payment, then 80%. Co-payment waived if patient treated for an injury or admitted to the hospital.	If provided at GHC facility - \$75 co-payment, waived if admitted to hospital directly from emergency.

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Pre-existing Condition	None.	None.
Chiropractic	80% up to 20 visits per calendar year.	Up to 10 visits per calendar year, subject to copayment; additional visits may be covered when approved by a GH provider,
Outpatient Mental Health	Up to 20 visits per calendar year – 1 st 10 visits covered at 80%; 2 nd 10 visits covered at 50%. Does not apply to "out of pocket" maximum.	\$10 co-payment per visit. Does not apply to "out of pocket" maximum.
Preventive Care Well Adult	Not subject to deductible. Paid at 100%.	In accordance with established Adult Well-Care schedule. \$10 co-payment per visit.
Preventive Care Well Child	Well Child Visits and Immunizations not subject to deductible. Paid at 100% including associated laboratory and X-ray charges. 7 visits between birth and 2 years of age 3 visits between 2 and 6 years of age 2 visits between 6 and 18 years of age	Every year up until 21 st birthday except for years 7, 9, 10. Multiple visits between birth and 2 yrs old – refer to GH Well-Child Visits and Immunizations. \$10 co-payment per visit.
Dental	No deductible. \$2,000 maximum per calendar year per person.	Group Health members are covered by the RedMed Plan for Dental coverage.
Vision	No deductible. One exam per calendar year at 80% of eligible charges. Vision hardware, e.g. eye glasses, contact lenses, are covered at 80% up to \$250/calendar year maximum.	Exam once every 12 months. \$10 co-payment. See RedMed for vision hardware coverage.

 $Note:\ This\ summary\ sheet\ is\ not\ a\ contract.$