

Kitsap County Medical Plans for 2010 Coverage (Plan changes in bold font)

| | Group Health | Premera Blue Cross PPO Plan |
|---|--|---|
| | In-Network Benefit Only | In-Network |
| Annual Deductible Out of pocket Max (per yr) | \$250/person \$750/family \$1,000/person/ \$3,000/ family | \$300/person \$900/family \$2,500/person & \$5,000/ family |
| Coinsurance | None | 90% (Non-preferred covered @ 60%) |
| Office Visits | First 4 visits - \$25 copay All others \$25 after deductible | \$25 copay |
| Lab & X-Ray (inc. mammograms) | First \$500 - covered in full Additional subject to deductible | Preventive (inc. mammography) covered in full Other - Deductible/Coinsurance |
| Prescription Drugs - Includes insulin and diabetic supplies | \$15 copay/Generic \$30 copay/Name | Tier 1 - \$10 copay, Tier 2 - \$30 copay Tier 3 - \$50 copay |
| Preventive Care & Immunizations | \$25 copay Not subject to deductible | \$25 copay Immunizations covered in full |
| Hospital Care | \$200 copay per day after deductible (max \$600) | Deductible/Coinsurance |
| Emergency Care Copay waived if admitted | GHC designated facility \$100 copay (non-designated \$150) after deductible | \$125 copay, Deductible/Coinsurance |
| Ambulance | 80% Not subject to deductible | 80% after deductible |
| Chiropractic (20 visit/yr limit) | \$25 copay after deductible | \$25 copay |
| Vision Exam | \$25 copay Not subject to deductible | \$25 copay |
| Eyeglasses or Contacts | \$250 every 12 months | \$250 per year |

Monthly Medical Premiums for Full-time Employees

| | County Monthly Contribution | Employee Monthly Contribution* | County Monthly Contribution | Employee Monthly Contribution* |
|-----------------------|--------------------------------|-----------------------------------|--------------------------------|-----------------------------------|
| Employee Only | 450.68 | \$10.00 | \$468.46 | \$15.00 |
| Employee + Spouse | \$863.38 | \$81.00 | \$903.04 | \$88.00 |
| Employee + Child(ren) | \$747.14 | \$59.00 | \$780.02 | \$66.00 |
| Employee + Family | \$1,159.84 | \$130.00 | \$1,214.62 | \$139.00 |

*Note: The Employee monthly contributions listed above do not include the \$25 spousal surcharge, if applicable.

Kitsap County Dental Plans for 2010 Coverage

| | WDS Plan C/2 | WDS Plan D/4 | Delta Care | Willamette |
|---|--|--------------|---|---|
| Class 1 - Preventive Exams, Prophys, X-rays, Seal- ants | 100% PPO Dentist/Premier/Non-Participating | | Delta Care Dentist Only | Willamette Provider Only |
| Class 2 - Restorative Restorations/Endodontics/Oral Surgery | 90% PPO 80% Premier/Non-Participating | | \$5 Copay per visit in addition to copay per visit. See copayment schedule for more info. | \$15 Copay per visit Nitroxide \$20 Emergency \$50 Specialist \$30 |
| Class 3 - Major (Crowns/ Partials) | 50% | | | |
| Annual Maximum | \$1,000 | \$2,000 | No Annual Max | No Annual Max |
| Orthodontia | 50% to a lifetime max \$2000 | | Adult copay: \$1600 Child copay: \$1200 | Copay: \$1800 Pre-Ortho: \$150 |

Monthly Dental Premiums for Full Time Employees

| | WDS C/2 | | WDS D/4 | | DeltaCare | | Willamette | |
|-------------------------|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|-------------------|---------------------|
| | County Monthly | Employee Monthly | County Monthly | Employee Monthly | County Monthly | Employee Monthly | County Monthly | Employee Monthly |
| Employee Only | \$55.94 | \$0.00 | \$55.94 | \$3.25 | \$27.07 | \$0.00 | \$53.11 | \$0.00 |
| Employee + 1 Dependent | \$80.94 | \$27.42 | \$80.94 | \$33.69 | \$52.07 | \$3.13 | \$78.11 | \$10.26 |
| Employee +2+ Dependents | \$80.94 | \$98.97 | \$80.94 | \$108.18 | \$52.07 | \$62.72 | \$78.11 | \$63.32 |