SKAGIT REGIONAL HEALTH

Medical Plan Comparisons

PEBB 2020 & Premera 2021

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MEDICAL INSURANCE TERMINOLOGY

Below are the definitions of common medical insurance terms that will be used throughout this document:

Deductible – A deductible is the amount of money you or your dependents must pay toward a health claim before your insurance company makes any payments for certain health care services rendered. The deductible applies unless the benefit is clearly marked as (DW) deductible waived. All medical plan options waive the deductible for preventive care services when using an in-network provider.

Out-of-Pocket Maximum – An out-of-pocket maximum is the maximum amount (deductible, coinsurance and copays) that you will have to pay for covered expenses under the medical plan in any one calendar year. Once the out-of-pocket limit is reached, the plan will cover in-network eligible expenses at 100%. Even if you have reached your out-of-pocket maximum for the year, you may still have to pay amounts over the allowed payments for out-of-network providers – this is called balance billing.

Coinsurance – Coinsurance is the amount expressed as a percentage of covered health services that you must pay. For example, if your coinsurance is 5%, you must pay 5% of the total cost of your service and the medical insurance will pay the additional 95%.

Preventive Care – Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes annual physical exams, immunizations, and scheduled cancer screenings (depending on your age and gender). Adults and children should get preventive screenings recommended for their age to detect health conditions early. In-network preventive care services are covered in full, deductible waived under all medical plan options.

2020 KAISER CDHP & 2021 PREMERA HDHP

	Kaiser CDHP In-Network Benefits	Premera HDHP In-Network Benefits
Calendar Year Deductible		
Individual Coverage	$1,400	
Family Coverage	$2,800 aggregate*	
Prescription Deductible	Shared with medical deductible	
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$5,100	$4,200
Family Coverage	$10,200 aggregate*	$8,400 aggregate (capped at $6,850 per individual)
Prescription Out-of-Pocket Maximum	Shared with medical out-of-pocket maximum	
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0% (DW)	
Professional		
Office Visit *(Primary and Specialist)*	You pay 10% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Diagnostic Lab & X-ray Services		
Chiropractic *(Kaiser - 10 visits / Premera – 12 visits)*		
Hearing Exam *(1 exam per calendar year)*		
Hospital/Facility		
Inpatient	You pay 10% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Outpatient		
Emergency Services		
Emergency Room	You pay 10% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Urgent Care		
Prescription Drugs		
Preventive	You pay $5 copay after deductible	Covered in full
Value Tier		N/A
Preferred Generic	You pay $20 copay after deductible	You pay 20% after deductible
Preferred Brand	You pay $40 copay after deductible	
Non-Preferred Generic/Brand	You pay 50% up to $250 after deductible	
Mail Order *(90-day supply)*	You pay 2x retail copay after deductible ($750 cap for non-preferred)	You pay 20% after deductible
Vision Care		
Vision Exam *(1 exam per calendar year)*	You pay 10% after deductible	Covered in full
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of frames or 50% for contacts (DW)	Plan pays for 1 pair standard frames or one-year supply of contacts (DW)

(DW) *= Deductible Waived*

**Aggregate:* *If more than one person is covered on the Kaiser, the family deductible will need to be satisfied before services are covered. In addition, the entire family out-of-pocket maximum will need to be satisfied before the plan pays 100% for in-network coverage.*

2020 KAISER CLASSIC PLAN & 2021 PREMERA CLASSIC PLAN

Calendar Year Deductible	Kaiser Classic Plan In-Network Benefits	Premera Classic Plan In-Network Benefits
Individual Coverage	$175	$250
Family Coverage	Up to $525	Up to $750
Prescription Deductible	$100 individual / Up to $300 family	N/A
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$2,000	SRH: $1,000 / PPO: $2,000
Family Coverage	Up to $4,000	Up to SRH: $2,000 / PPO $4,000
Prescription Out-of-Pocket Maximum	$2,000 per individual	
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0% (DW)	
Professional		
Primary Care Office Visit	You pay $15 copay (DW)	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Specialist Office Visit	You pay $30 copay (DW)	
Diagnostic Lab & X-ray Services	Covered in full after deductible	
Chiropractic *(Kaiser - 10 visits / Premera – 12 visits)*	You pay $15 copay after deductible	
Hearing Exam *(1 exam per calendar year)*		
Hospital/Facility		
Inpatient	You pay $150 copay/day after deductible (capped at $750 per admission)	SRH/PPO: You pay $200 copay/day (capped at $600 PCY) You pay deductible and 20% for PPO
Outpatient	You pay $150 copay after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Emergency Services		
Emergency Room	You pay $250 copay after deductible	SRH: You pay $250 copay then 5% (DW) PPO: You pay $250 copay then 20% after deductible
Urgent Care	You pay $15 copay after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Prescription Drugs		
Value Based	You pay $5 copay (DW)	N/A
Preferred Generic	You pay $20 copay (DW)	You pay 5% (DW) for all generics
Preferred Brand	You pay $40 copay after Rx deductible	You pay 10% (DW)
Non-Preferred	You pay 50% after Rx deductible ($250 cap)	You pay 30% (DW) brand only
Specialty	Applicable cost share listed above	You pay 50% up to $250 (DW)
Mail Order *(90-day supply)*	You pay 2x copay after deductible ($750 cap for non-preferred)	Same as retail cost shares
Vision Care		
Vision Exam *(1 exam per calendar year)*	You pay $15 copay after deductible	Covered in full You pay 0%
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of frames or 50% for contacts (DW)	Plan pays for 1 pair standard frames or 1 year of contacts (DW)

(DW) *= Deductible Waived*

2020 KAISER SOUNDCHOICE & 2021 PREMERA CLASSIC PLAN

Calendar Year Deductible	Kaiser SoundChoice Plan In-Network Benefits	Premera Classic Plan In-Network Benefits
Individual Coverage	$250	
Family Coverage	Up to $750	
Prescription Deductible	$100 individual / Up to $300 family	N/A
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$2,000	SRH: $1,000 / PPO: $2,000
Family Coverage	Up to $4,000	Up to SRH: $2,000 / PPO $4,000
Prescription Out-of-Pocket Maximum	$2,000 per individual	
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0% (DW)	
Professional		
Primary Care Office Visit	You pay 15%, deductible waived for first visit of the year	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Specialist Office Visit	You pay 15% after deductible	
Diagnostic Lab & X-ray Services		
Chiropractic *(Kaiser - 10 visits / Premera – 12 visits)*		
Hearing Exam *(1 exam per calendar year)*		
Hospital/Facility		
Inpatient	You pay $200/day after deductible (capped at $1,000 per admission)	SRH/PPO: You pay $200 copay/day (capped at $600 PCY) You pay deductible and 20% for PPO
Outpatient	You pay 15% after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Emergency Services		
Emergency Room	You pay $75 copay then 15% after deductible	SRH: You pay $250 copay then 5% (DW) PPO: You pay $250 copay then 20% after deductible
Urgent Care	You pay 15% after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Prescription Drugs		
Value Based	You pay $5 copay (DW)	N/A
Preferred Generic	You pay $15 copay (DW)	You pay 5% (DW) for all generics
Preferred Brand	You pay $60 copay after Rx deductible	You pay 10% (DW)
Non-Preferred Generic/Brand	You pay 50% after Rx deductible	You pay 30% (DW) brand only
Preferred Specialty	You pay $150 after Rx deductible	You pay 50% up to $250 (DW)
Non-Preferred Specialty	You pay 50% after Rx deductible ($400 cap)	
Mail Order *(90-day supply of non-specialty Rx)*	2x retail copay	Same as retail cost shares
Vision Care		
Vision Exam *(1 exam per calendar year)*	You pay 15% (DW)	Covered in full
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of frames or 50% for contacts (DW)	Plan pays for 1 pair standard frames or 1 year of contacts (DW)

(DW) *= Deductible Waived*

2020 KAISER VALUE PLAN & 2021 PREMERA VALUE PLAN

Calendar Year Deductible	Kaiser Value Plan In-Network Benefits	Premera Value Plan In-Network Benefits
Individual Coverage	$250	
Family Coverage	Up to $750	
Prescription Deductible	$100 individual / Up to $300 family	N/A
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$3,000	
Family Coverage	Up to $6,000	
Prescription Out-of-Pocket Maximum	$2,000 per individual	Shared with medical
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full	
Professional		
Primary Care Office Visit	You pay $30 copay after deductible	SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Specialist Office Visit	You pay $50 copay after deductible	SRH: You pay $50 copay (DW) PPO: You pay $50 copay after deductible
Diagnostic Lab & X-ray Services	Covered in full after deductible	SRH: Covered in full PPO: You pay 10% after deductible
Chiropractic *(Kaiser: 10 / Premera: 12 visits)*	You pay $30 copay after deductible	SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Hearing Exam *(1 exam per calendar year)*		
Hospital/Facility		
Inpatient	You pay $250 copay/day, up to $1,250 per admission after deductible	SRH/PPO: You pay $200 copay/day (capped at $600 PCY) You pay deductible and 10% for PPO
Outpatient	You pay $200 copay after deductible	SRH: 100% (DW) PPO: You pay 10% after deductible
Emergency Services		
Emergency Room	You pay $300 copay after deductible	SRH: You pay $300 copay (DW) PPO: You pay $300 copay, 10% after deductible
Urgent Care	You pay $30 copay after deductible	SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Prescription Drugs		
Value Based	You pay $5 copay (DW)	N/A
Preferred Generic	You pay $25 copay (DW)	You pay $5 copay (DW) all generics
Preferred Brand	You pay $50 copay after Rx deductible	You pay $25 copay (DW)
Non-Preferred	You pay 50% after Rx deductible	You pay $50 copay (DW) brand only
Preferred Specialty	You pay $150 after Rx deductible	You pay 50%
Non-Preferred Specialty	You pay 50% after deductible, up to $400	
Mail Order *(90-day supply of non-specialty Rx)*	You pay 2x retail copay	
Vision Care		
Vision Exam *(1 exam per calendar year)*	You pay $30 copay after deductible	Covered in full
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of frames or 50% for contacts (DW)	Plan pays for 1 pair standard frames or 1 year of contacts (DW)

(DW) *= Deductible Waived*

2020 UMP CDHP & 2021 PREMERA HDHP

Calendar Year Deductible	**UMP CDHP In-Network Benefits**	**Premera HDHP In-Network Benefits**
Individual Coverage	$1,400	
Family Coverage	$2,800 aggregate*	
Prescription Deductible	Shared with medical deductible	
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$4,200	
Family Coverage	$8,400 aggregate* (capped at $6,850 per person)	
Prescription Out-of-Pocket Maximum	Shared with medical out-of-pocket maximum	
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0% (DW)	
Professional		
Primary Care Office Visit	Pref: You pay 15% after deductible Par: You pay 40% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Specialist Office Visit		
Diagnostic Lab & X-ray Services		
Chiropractic *(UMP - 10 visits / Premera – 12 visits)*		
Hearing Exam		
Hospital/Facility		
Inpatient	Pref: You pay 15% after deductible Par: You pay 40% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Outpatient		
Emergency Services		
Emergency Room	You pay 15% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Urgent Care	Pref: You pay 15% after deductible Par: You pay 40% after deductible	
Prescription Drugs		
Preventive Medications	Covered in full	
All Other Medications	You pay 15% after deductible	SRH: You pay 10% after deductible PPO: You pay 20% after deductible
Mail Order *(90-day supply)*	You pay 15% after deductible	You pay 20% after deductible
Vision Care		
Vision Exam *(1 exam per calendar year)*	Covered in full	
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of standard frames or a one-year supply of contacts (DW)	

***(DW)** = Deductible Waived*

*****Aggregate:** If more than one person is covered on the CHDP, the family deductible will need to be satisfied before services are covered. In addition, the entire family out-of-pocket maximum will need to be satisfied before the plan pays 100% for in-network coverage ($6,850 cap per individual).*

2020 UMP CLASSIC PLAN & 2021 PREMERA CLASSIC PLAN

Calendar Year Deductible	UMP Classic Plan In-Network Benefits	Premera Classic Plan In-Network Benefits
Individual Coverage	$250	
Family Coverage	Up to $750	
Prescription Deductible	$100 individual / Up to $300 family	N/A
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$2,000	SRH: $1,000 / PPO: $2,000
Family Coverage	Up to $4,000	Up to SRH: $2,000 / PPO $4,000
Prescription Out-of-Pocket Maximum	$2,000 per individual	
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0% (DW)	
Professional		
Primary Care Office Visit	Pref: You pay 15% after deductible Par: You pay 40% after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Specialist Office Visit		
Diagnostic Lab & X-ray Services		
Chiropractic *(UMP - 10 visits / Premera – 12 visits)*		
Hearing Exam *(1 exam per calendar year)*	Covered in full	
Hospital/Facility		
Inpatient	You pay $200 copay/day ($600 cap PCY) after deductible + 15%	SRH/PPO: You pay $200 copay/day (capped at $600 PCY) You pay deductible + 20% for PPO
Outpatient	Pref: You pay 15% after deductible Par: You pay 40% after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Emergency Services		
Emergency Room	You pay $75 copay, then 15% after deductible	SRH: You pay $250 copay then 5% (DW) PPO: You pay $250 copay then 20% after deductible
Urgent Care	Pref: You pay 15% after deductible Par: You pay 40% after deductible	SRH: You pay 5% (DW) PPO: You pay 20% after deductible
Prescription Drugs		
Preventive Drugs	Covered in full	You pay 5% (DW)
Value Tier	You pay 5% up to $10 (DW)	N/A
Tier 1 – Generic	You pay 10% up to $25 (DW)	You pay 5% (DW)
Tier 2 – Preferred Brand	You pay 30% up to $75 after Rx deductible	You pay 10% (DW)
Tier 3 – Non-Preferred Brand	You pay 50% after Rx deductible ($150 cap for specialty Rx)	You pay 30% (DW)
Tier 4 – Specialty		You pay 50% up to $250 (DW)
Mail Order	Same as retail cost shares	
Vision Care		
Vision Exam *(1 exam per calendar year)*	Covered in full	
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of standard frames or a one-year supply of contacts (DW)	

(DW) = *Deductible Waived*
PCY = *Per Calendar Year*

2020 UMP PLUS PLAN & 2021 PREMERA VALUE PLAN

Calendar Year Deductible	**UMP Plus Plan In-Network Benefits**	**Premera Classic Plan In-Network Benefits**
Individual Coverage	$125	$250
Family Coverage	Up to $375	Up to $750
Prescription Deductible	N/A	
Calendar Year Out-of-Pocket Maximum (includes deductible, coinsurance and copays)		
Individual Coverage	$2,000	$3,000
Family Coverage	Up to $4,000	Up to $6,000
Prescription Out-of-Pocket Maximum	$2,000 per individual	Shared with medical
Preventive Care		
Office Visit *(Preventive x-ray, labs, routine immunizations, well-childcare, mammograms)*	Covered in full You pay 0%	
Professional		
Primary Care Office Visit	Core*: Covered in full Support: You pay 15% after deductible	SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Specialist Office Visit	You pay 15% after deductible	SRH: You pay $50 copay (DW) PPO: You pay $50 copay after deductible
Diagnostic Lab & X-ray Services		SRH: Covered in full PPO: You pay 10% after deductible
Chiropractic *(UMP: 10 visits / Premera: 12 visits)*		SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Hearing Exam *(1 exam per calendar year)*	Covered in full	
Hospital/Facility		
Inpatient	You pay $200 copay/day ($600 cap PCY) after deductible + 15%	SRH/PPO: You pay $200 copay/day (capped at $600 PCY) You pay deductible + 10% for PPO
Outpatient	You pay 15% after deductible	SRH: 100% (DW) PPO: You pay 10% after deductible
Emergency Services		
Emergency Room	You pay $75 copay, then 15% after deductible	SRH: You pay $300 copay (DW) PPO: You pay $300 copay, 10% after deductible
Urgent Care	You pay 15% after deductible	SRH: You pay $30 copay (DW) PPO: You pay $30 copay after deductible
Prescription Drugs		
Preventive Drugs	Covered in full	You pay $5 copay (DW)
Value Tier	You pay 5% up to $10 (DW)	N/A
Tier 1 – Generic	You pay 10% up to $25 (DW)	You pay $5 copay (DW)
Tier 2 – Preferred Brand	You pay 30% up to $75 (DW)	You pay $25 copay (DW)
Tier 3 – Non-Preferred Brand	You pay 50% (DW) ($150 cap for specialty Rx)	You pay $50 copay (DW)
Tier 4 – Specialty		You pay 50%
Mail Order *(90-day supply)*	Same as retail cost shares	2x retail copays
Vision Care		
Vision Exam *(1 exam per calendar year)*	Covered in full	
Vision Hardware Adult *(every 2 years)*	Plan pays up to $150 (DW)	
Vision Hardware Children *(every year)*	Plan pays for 1 pair of standard frames or a one-year supply of contacts (DW)	

***(DW)** = Deductible Waived /* **PCY** *= Per Calendar Year*

***Core:** UMP Members can choose between the UW Medicine Accountable Care or Puget Sound High Value Network for their "Core" network.*