# Port of Seattle 2019 Medical Plans
## Comparison of Coverage

**Effective January 1, 2019**

This is a summary of the benefits available under your health care plan's contract. Please see Benefits Booklets for complete detail. This summary does not include all covered items, limitations and exclusions.

| Type of Coverage | Kaiser Permanente Core Plan | Aetna High Deductible Health Plan (HDHP) | Aetna Deductible Plan |
|---|---|---|---|
| **Providers** | You must use Kaiser Permanente Core providers, unless your Kaiser Permanente Core provider refers you outside the network. | You must use an Aetna Choice POS II network provider to receive maximum benefits. It is the member's responsibility to ensure the chosen providers are in this network. *If out-of-network providers are used, coverage will be significantly less, balance billing may occur, and in some cases, services will not be covered.* | You must use an Aetna Choice POS II network provider to receive maximum benefits. It is the member's responsibility to ensure the chosen providers are in this network. *If out-of-network providers are used, coverage will be significantly less, balance billing may occur, and in some cases, services will not be covered.* |
| **Alternative Providers** | May self-refer to an acupuncturist for up to 12 visits/year. Self-refer to naturopath for up to 3 visits per medical condition per year; additional with approval. Self-refer to nutritionist. Massage therapy requires pre-authorization. | May use acupuncturist, nutritionist, naturopath, massage therapist. | May use acupuncturist, nutritionist, naturopath, massage therapist. |
| **Deductible** – paid by member and applies to all expenses unless waived. | None | **In-network:** $1,400/employee only; $2,800/employee & family per calendar year.<br>**Out of network:** $2,100/employee only; $4,200/employee & family per calendar year. | **In-network:** $400/person; $1,200 family maximum per calendar year.<br>**Out-of-network:** $600/person; $1,800 family per calendar year. |
| **Copayment** – paid by member | $35 copay per outpatient visit, plus 20% coinsurance. | None, unless specified. | None, unless specified. |
| **Coinsurance** – paid by member | 20% of allowable charges up to the annual out-of-pocket maximum for in-network services. | 20% of allowable charges up to the annual out-of-pocket maximum for in-network services. 40% of allowable charges up to the annual out of pocket maximum for out-of-network services. | 20% of allowable charges up to the annual out-of-pocket maximum for in-network services. 40% of allowable charges up to the annual out-of-pocket maximum for out-of-network services. |
| **Out of Pocket Maximum (Stop Loss)** – including deductible, coinsurance and copays, if any. Paid by member. | $1,500 per person ($3,000 family) per calendar year. | **In-network:** $3,000/employee only ($6,000 employee & family) per calendar year.<br>**Out-of-network:** $9,000/employee only; $18,000/employee & family per calendar year. | **In-network:** $1,800/person ($5,400/family) per calendar year.<br>**Out-of-network:** $5,400/person; $16,200/family per calendar year. |

| Type of Coverage | Kaiser Permanente Core Plan | Aetna High Deductible Health Plan (HDHP) | Aetna Deductible Plan |
|---|---|---|---|
| **Prescription Drugs** – at participating retail pharmacies | For 30 day supply, $15 copay for generic drugs and $30 copay for preferred brand name drugs. | For 30 to 90 day supply, paid at 80% after deductible is met up to out-of-pocket maximum. Deductible waived for certain generic preventative medications (see list). | For 30 day supply, $5 copay for generic, $35 copay for preferred brand name, and $50 copay for non-preferred brand name. 30 to 90 day supply can be purchased with 1x, 2x or 3x copay applying. |
| **Prescription Drugs** – 90-day supply by mail order | $30 copay for a 90-day generic supply and $60 copay for 90-day preferred brand name supply. | Paid at 80% after deductible is met up to out-of-pocket maximum. | $10 copay for generic, $70 copay for preferred brand name, and $100 copay for non-preferred brand name. |
| **Preventive Services** | Paid at 100% (see Kaiser Permanente website for details) | Paid at 100% in-network. *Some out-of-network not covered.* (see Aetna website for details) | Paid at 100% in-network. *Some out-of-network not covered.* (see Aetna website for details) |
| **Telemedicine** | $35 copay per visit plus 20% coinsurance | $40 per visit before deductible is met; then, paid at 80%. When Teladoc provider is used. | $40 per visit before deductible is met; then, paid at 80%. When Teladoc provider is used. |
| **X-Ray and Lab Charges** | Paid at 80% | Paid at 80% in network, 60% out-of-network | Paid at 80% in network, 60% out-of-network |
| **Hospital Services** Inpatient Confinements | Paid at 80% | Paid at 80% in network, 60% out of network | Paid at 80% in network, 60% out of network |
| Outpatient Surgery Center | $50 copay, plus 20% coinsurance | Paid at 80% in network, 60% out of network | Paid at 80% in network, 60% out of network |
| **Emergency Room** | $100 copayment per visit (waived if admitted from emergency room), plus 20% coinsurance. | Paid at 80% in-network and out-of-network | $75 copay (waived if admitted from the emergency room), plus 20% coinsurance in-network and out-of-network |
| **Mental Health Care** | Outpatient: $35 copay per visit, plus 20% coinsurance. Inpatient: Paid at 80%. | **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network | **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network. |
| **Chemical Dependency** | **Outpatient:** $35 copay per visit, plus 20% coinsurance **Inpatient:** Paid at 80%. | **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network | **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network |
| **Rehabilitative Care** | **Benefit limits:** 60 outpatient visits and 60 inpatient days per calendar year. **Outpatient:** $35 copay per visit, plus 20% coinsurance. **Inpatient:** Paid at 80%. | Physical, occupational, speech and massage therapy. **Benefit limits:** 45 outpatient visits and 30 inpatient days per calendar year. Cardiac & pulmonary rehabilitation: 36 days. **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network | Physical, occupational, speech and massage therapy. **Benefit limits:** 45 outpatient visits and 30 inpatient days per calendar year. Cardiac & pulmonary rehabilitation: 36 days. **Outpatient and inpatient:** Paid at 80% in-network, 60% out-of-network |
| **Chiropractic Care & Manipulative Therapy** | Self-refer to a Group Health-designated Specialist for up to 10 visits per year. $35 copay per visit, plus 20% coinsurance. Additional visits when approved. | 12 spinal adjustments per calendar year. Paid at 80% in-network and 60% out-of-network | 12 spinal adjustments per calendar year. Paid at 80% in-network and 60% out-of-network |
| **Routine Hearing Exam** | $35 copay plus 20% coinsurance. | 1 exam per calendar year. Paid at 80% in-network, 60% out-of-network | 1 exam per calendar year. Paid at 80% in-network, 60% out-of-network |

| Type of Coverage | Kaiser Permanente Core Plan | Aetna High Deductible Health Plan (HDHP) | Aetna Deductible Plan |
|---|---|---|---|
| **Hearing Hardware** | Covered up to $1,000 per ear (i.e., $2,000 for both ears), every 36 months. | In-network and out-of-network: Paid at 80% of allowable charges, up to a maximum benefit of $3,000 per enrollee in a period of three (3) consecutive calendar years. | In-network and out-of-network: Deductible waived. Paid at 80% of allowable charges, up to a maximum benefit of $3,000 per enrollee in a period of three (3) consecutive calendar years. |