

Port of Seattle 2020 Medical Plans

Comparison of Coverage

Effective January 1, 2020

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. <i>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.</i>	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. <i>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.</i>
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: \$1,450/employee only; \$2,900/employee & family per calendar year. Out of network: \$2,175/employee only; \$4,350/employee & family per calendar year.	In-network: \$500/person; \$1,500 family maximum per calendar year. Out-of-network: \$750/person; \$2,250 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.

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Out of Pocket Maximum – including deductible, coinsurance and copays, if any. Paid by member.	\$1,500 per person (\$3,000 family) per calendar year.	In-network: \$3,200/employee only (\$6,400 employee & family) per calendar year. Out-of-network: \$9,600/employee only; \$19,200/employee & family per calendar year.	In-network: \$2,000/person (\$6,000/family) per calendar year. Out-of-network: \$6,000/person; \$18,000/family per calendar year.
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. <i>Some out-of-network not covered.</i> (see Aetna website for details)	Paid at 100% in-network. <i>Some out-of-network not covered.</i> (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.

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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
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.