2022 **PEBB medical benefits comparison**

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Use the following charts to briefly compare the deductibles, out-of-pocket limits, per-visit out-of-pocket costs, and prescription drug costs for PEBB medical plans. Most coinsurance does not apply until after you have paid your annual deductible unless noted that the deductible is waived. Under some plans, copays apply regardless of meeting your deductible, unless enrolled in a consumer-directed health plan (CDHP) with a health savings account. You must pay the deductible first for most covered services before copays or coinsurance apply to a CDHP. Benefits and visit limits listed as per year are based on calendar years (January 1 through December 31). Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. If anything in these charts conflicts with the plan's certificate of coverage (COC), the COC takes precedence and prevails.

What you pay	Managed Care and Exclusive Provider Organization (EPO) Plans					
	Kaiser Foundation Health Plan of the Northwest		Kaiser Foundation Health Plan of Washington			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Annual costs						
Medical deductible	$300/person $900/family	$1,400/person $2,800/family	$175/person $525/family	$125/person $375/family	$250/person $750/family	$1,400/person $2,800/family
Medical out-of-pocket limit	$2,000/person $4,000/family	$5,100/person $10,200/family	$2,000/person; $4,000/family		$3,000/person $6,000/family	$5,100/person $10,200/family
Prescription drug deductible	None	Combined with medical deductible	$100/person; $300/family (does not apply to Value or Tier 1 drugs)			Combined with medical deductible (does not apply to preventive drugs)
Prescription drug out-of-pocket limit	Combined with medical limit		$2,000/person; $8,000/family			Combined with medical limit
Emergency services						
Ambulance (air or ground/trip)	15%		20% (deductible waived)			10%
Emergency room			$250	$75 + 15%	$300	
Hearing services						
Hearing aids	$0 one per ear every 60 months		$0 one per ear any consecutive 60 months			$0 one per ear any consecutive 60 months
Routine annual hearing exam	$35	$30	$15 (primary care) $30 (specialist)	$0 (primary care) 15% (specialist)	$30 (primary care) $50 (specialist)	10%

The information in this document is accurate at the time of printing. Contact the plans or review the COCs before making decisions.

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan (administered by Regence BlueShield)			
	Classic	Plus	Select	CDHP
Annual costs				
Medical deductible	$250/person $750/family	$125/person $375/family	$750/person $2,250/family	$1,400/person $2,800/family
Medical out-of-pocket limit	$2,000/person $4,000/family		$3,500/person $7,000/family	$4,200/person $8,400/family; not to exceed $7,000/member
Prescription drug deductible	$100/person; $300/ family (for Tier 2 and specialty, except insulins)	None	$250/person; $750/ family (for Tier 2 and specialty, except insulins)	Combined with medical deductible
Prescription drug out-of-pocket limit	$2,000/person; $4,000/family			Combined with medical limit; not to exceed $7,000/member
Emergency services				
Ambulance (air or ground/trip)	20%			
Emergency room	$75 + 15%		$75 + 20%	15%
Hearing services				
Hearing aids	$0 (one per ear every 5 years)			
Routine annual hearing exam	$0			15%

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What you pay	Managed Care and Exclusive Provider Organization (EPO) Plans					
	Kaiser Foundation Health Plan of the Northwest		Kaiser Foundation Health Plan of Washington			
	Classic	CDHP	Classic	SoundChoice	Value	CDHP
Hospital care						
Inpatient	15%		$150/day up to $750/admission	$500/admission	$250/day up to $1,250/ admission	10%
Outpatient			$150	15%	$200	
Office visits						
Behavioral health	$25[1]	$20[1]	$15	$0	$30	10%
Preventive care (deductible waived)	$0		$0			
Primary care	$25[1]	$20[1]	$15	$0	$30	10%
Specialist	$35	$30	$30	15%	$50	
Telemedicine/virtual care	$0		$0			
Urgent care	$45	$40	$15 (primary care) $30 (specialist)	15%	$30 (primary care) $50 (specialist)	10%
Therapies (max number of visits/year)						
Acupuncture	$35 (Self-referred: 12 visits/year; Physician-referred: no limit)	$30 (Self-referred: 12 visits/year; Physician-referred: no limit)	$15 (12 visits/year)	$0 (12 visits/year)	$30 (12 visits/year)	10% (12 visits/year)
Chiropractic/spinal manipulations			$15 (10 visits/year)	$0 (10 visits/year)	$30 (10 visits/year)	10% (10 visits/year)
Massage therapy	$25 (Self-referred: 12 visits/year)		$30 (60 combined therapy visits/ year)	15% (16 separate visits/year)	$50 (60 combined therapy visits/ year)	10% (60 combined therapy visits/ year)
Physical, occupational, speech, and neurodevelopmental therapy	$35 (60 combined visits/year)	$30 (60 combined visits/year)		15% (60 combined visits/year)		
Vision care						
Glasses and contact lenses	Any amount over $150 every 2 years		Any amount over $150 every 24 months			
Routine annual eye exam	$25	$20	$15 ($30 specialty)	$0 (15% specialty)	$30 ($50 specialty)	10%

1. *$0 ages 17 and under.*

What you pay	Preferred Provider Organization (PPO) Plans			
	Uniform Medical Plan (administered by Regence BlueShield)			
	Classic	Plus	Select	CDHP
Hospital care				
Inpatient	$200/day up to $600 15% professional services (0% for behavioral health)		$200/day, up to $600 20% professional services (0% for behavioral health)	15%
Outpatient	15%		20%	15%
Office visits				
Behavioral health	15%		20%	15%
Preventive care (deductible waived)	$0			
Primary care	15%	$0	20%	15%
Specialist	15%		20%	15%
Telemedicine/virtual care	Varies, see certificate of coverage			
Urgent care	15%		20%	15%
Therapies (max number of visits/year)				
Acupuncture	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Chiropractic/spinal manipulations	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Massage therapy	$15 (24 visits/year)			$15 after deductible (24 visits/year)
Physical, occupational, speech, and neurodevelopmental therapy	15% (60 combined visits/year)		20% (60 combined visits/year)	15% (60 combined visits/year)
Vision care				
Glasses and contact lenses	$0 up to the allowed amount for one pair of standard lenses and frames once every 2 years; or any amount over $150 for elective contact lenses instead of frames and lenses once every 2 years ($30 fitting fee for contact lenses)			
Routine annual eye exam	$0			

Prescription drug benefits

Amounts in the following tables show what you pay for prescription drugs. Under the prescription drug benefit, most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.
Note: All plans cover legally-required preventive prescription drugs at 100 percent of allowed amount with no deductible.

Drug tiers	Kaiser Foundation Health Plan of the Northwest			
	Retail (up to 30-day supply)		**Mail-order** (up to 90-day supply)	
	Classic	CDHP	Classic	CDHP
Generic	$15		$30	
Preferred brand-name	$40		$80	
Non-preferred brand-name	$75		$150	
Specialty	50% up to $150		Not covered	

Drug tiers	Kaiser Foundation Health Plan of Washington							
	Retail (up to 30-day supply)				**Mail-order** (up to 90-day supply)			
	Classic	SoundChoice	Value	CDHP	Classic	SoundChoice	Value	CDHP
Value	$5			Not covered	$10			Not covered
Preferred generic	$20	$15	$25	$20	$40	$30	$50	$40
Preferred brand-name	$40	$60	$50	$40	$80	$120	$100	$80
Non-preferred generic and brand-name	50% up to $250	50%		50% up to $250	50% up to $750	50%		50% up to $750
Preferred specialty	Not covered	$150		Not covered	Not covered			
Non-preferred specialty		50% up to $400						

Drug tiers	Uniform Medical Plan							
	Retail and mail order (up to 30-day supply)				**Retail and mail order** (up to 90-day supply)			
	Classic	Plus	Select	CDHP	Classic	Plus	Select	CDHP
Value	5% up to $10[1]			15%; Insulins 5% up to $10[1]	5% up to $30[1]			15%; Insulins 5% up to $30[1]
Tier 1 (Primarily low-cost generic)	10% up to $25[1]			15%; Insulins 10% up to $25[1]	10% up to $75[1]			15%; Insulins 10% up to $75[1]
Tier 2 (Preferred brand-name drugs and high-cost generic)	30% up to $75			15%; Insulins 30% up to $75[1]	30% up to $225			15%; Insulins 30% up to $225[1]

1. *Deductible is waived.*