

2021 PEBB Members

Rates and Benefit Summary

This is an overview of benefits. See your Evidence of Coverage for full benefit details.

	Kaiser Permanente WA Classic		Kaiser Permanente WA Value		Kaiser Permanente WA Consumer Directed Health Plan (CDHP)	
Annual costs						
Medical deductible*	Individual: \$175 / Family: \$525		Individual: \$250 / Family: \$750		Individual: \$1,400	
Rx deductible	Individual: \$100 / Family: \$300 Prescription drug deductible waived on value and tier 1 drugs		Individual: \$100 / Family: \$300 Prescription drug deductible waived on value and tier 1 drugs		Family: \$2,800 Combined deductible for medical services and prescription drugs	
Out-of-pocket limit	Individual: \$2,000 Family: \$4,000		Individual: \$3,000 Family: \$6,000		Individual: \$5,100 Family: \$10,200	
Rx out-of-pocket limit	Individual: \$2,000 Family: \$8,000		Individual: \$2,000 Family: \$8,000		Prescription drug copays and coinsurance apply to the medical out-of-pocket limit.	
Benefits						
Primary care visit**	\$15		\$30		10%	
Preventive care visit	\$0 ♦		\$0 ♦		\$0 ♦	
Specialty care visit**	\$30		\$50		10%	
Prescription drugs	Retail 30-day supply	Mail-order 90-day supply	Retail 30-day supply	Mail-order 90-day supply	Retail 30-day supply	Mail-order 90-day supply
Value tier	\$5 ♦	\$10 ♦	\$5 ♦	\$10 ♦	N/A†	N/A†
Preferred generic (tier 1)	\$20 ♦	\$40 ♦	\$25 ♦	\$50 ♦	\$20**	\$40**
Preferred brand (tier 2)	\$40	\$80	\$50	\$100	\$40**	\$80**
Non-preferred (tier 3)	50% to \$250	50% to \$750	50%	50%	50% to \$250**	50% to \$750**
Preferred specialty (tier 4)	N/A	N/A	\$150	N/A	N/A	N/A
Non-preferred specialty (tier 5)	N/A	N/A	50% to \$400	N/A	N/A	N/A
Manipulative therapy	\$15 per visit, 10 visits PCY		\$30 per visit, 10 visits PCY		10%, 10 visits PCY	
Naturopathy	\$15 per visit, 3 visits per medical diagnosis PCY		\$30 per visit, 3 visits per medical diagnosis PCY		10%	
Acupuncture	\$15 per visit, 12 visits PCY		\$30 per visit, 12 visits PCY		10%, 12 visits PCY	
Mental health	Inpatient: \$150 copay per day to a max. of \$750 per admit Office visit: \$15		Inpatient: \$250 copay per day to a max. of \$1,250 per admit Office visit: \$30		Inpatient: 10% Office visit: 10%	
Hospital	Inpatient: \$150 copay per day to a max. of \$750 per admit Outpatient: \$150 copay		Inpatient: \$250 copay per day to a max. of \$1,250 per admit Outpatient: \$200 copay		Inpatient: 10% Outpatient: 10%	

(continues on back)

	Kaiser Permanente WA Classic	Kaiser Permanente WA Value	Kaiser Permanente WA Consumer Directed Health Plan (CDHP)
Benefits (continued)			
Ambulance	20% coinsurance ♦	20% coinsurance ♦	10%
Emergency care	\$250	\$300	10%
Lab and radiology	\$0; MRI, CT, or PET scan \$30	\$0; MRI, CT, or PET scan \$50	10%
Maternity care Applicable outpatient preventive services are covered as preventive	Inpatient: \$150 copay per day to a max. of \$750 per admit Office visits: \$15**	Inpatient: \$250 copay per day to a max. of \$1,250 per admit Office visits: \$30**	Inpatient: 10% Office visits: 10%
Rehabilitation therapy† Rehabilitation visits are a total of combined therapy visits PCY	Inpatient: \$150 copay per day to a max. of \$750 per admit (60 days PCY) Outpatient: \$30 (60 visits PCY)	Inpatient: \$250 copay per day to a max. of \$1,250 per admit (60 days PCY) Outpatient: \$50 (60 visits PCY)	Inpatient: 10% (60 days PCY) Outpatient: 10% (60 visits PCY)
Vision exam	\$15	\$30	10%
Glasses and contacts For members ages 19 and older	Enrollee pays any amount over \$150 every 24 months ♦	Enrollee pays any amount over \$150 every 24 months ♦	Enrollee pays any amount over \$150 every 24 months ♦
Pediatric glasses and contacts For members up to age 19	Enrollee pays \$0 for one set of glasses or 50% coinsurance for contact lenses PCY ♦	Enrollee pays \$0 for one set of glasses or 50% coinsurance for contact lenses PCY ♦	Enrollee pays \$0 for one set of glasses or 50% coinsurance for contact lenses PCY ♦
Hearing exam	\$15**	\$30**	10%
Hearing aid benefit	One hearing aid per ear covered in full every 60 months ♦	One hearing aid per ear covered in full every 60 months ♦	One hearing aid per ear covered in full every 60 months

2021 monthly premiums

State or higher education employee***

Employee	\$189	\$112	\$26
Employee & spouse**	\$388	\$234	\$62
Employee & child(ren)	\$331	\$196	\$46
Employee, spouse** & child(ren)	\$530	\$318	\$82

Non-Medicare retiree

Subscriber	\$775	\$699	\$619
Subscriber & spouse**	\$1,545	\$1,392	\$1,228
Subscriber & child(ren)	\$1,353	\$1,219	\$1,090
Subscriber, spouse** & children	\$2,123	\$1,912	\$1,641

PCY = Per calendar year ♦Not subject to annual deductible. ‡ Certain generic prescription medications considered preventive are covered in full before deductible is met. †† Medical deductible applies to these prescription drug benefits.

*Annual deductible applies to most services. **Specialty care visit copay will apply if service is rendered by a specialist. See Evidence of Coverage for the list of specialty care providers. † Services with mental health diagnoses are covered with no limit.

***If you are a PEBB Continuation Coverage subscriber, visit hca.wa.gov/pebb-continuation to see your monthly premiums.

♦♦Or state-registered domestic partner.

Call our dedicated Member Services phone line for PEBB members at **1-866-648-1928**, Monday through Friday, 8 a.m. to 6 p.m., or contact your payroll or personnel office. If you are a non-Medicare retiree or PEBB Continuation Coverage subscriber, call the PEBB Program at **1-800-200-1004**.