

2021 Medical Plans Comparison – Most/Local 77 Plans

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at <https://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/local-77-plans>.

Kaiser Permanente	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
Deductible (per calendar year)				
No deductible	\$400 per person \$1,200 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies	\$1,000 per person \$3,000 per family	\$100 per person \$300 per person Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the inpatient copay or emergency room copay applies	\$450 per person \$1,350 per family
Annual Out of Pocket Maximum (OOP Max) includes copays and coinsurance after any applicable deductible. Excludes prescription drug copays				
\$2,000 per person \$4,000 per family	\$1,000 per person \$3,000 per family	\$2,000 per person \$6,000 per family	\$2,000 per person \$4,000 per family	\$3,000 per person \$6,000 per family
Total Annual Out of Pocket Maximum: includes medical copays, coinsurance, and the deductible. Excludes prescription drug copays				
\$2,000 per person \$4,000 per family	\$1,400 per person \$4,200 per family	\$3,000 per person \$9,000 per family	\$2,100 per person \$4,300 per family	\$3,450 per person \$7,350 per family
Hospital Copay				
\$200 per admission	\$200 copay per admission	\$200 copay per admission	\$200 copay per admission	\$200 copay per admission
Hospital Pre-admission Authorization				
Except for maternity or emergency admissions, must be authorized by Kaiser Permanente	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission. Member responsible for obtaining precertification of out-of-network care.	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care

Kaiser Permanente	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
Choice of Providers				
All care and services provided at Kaiser Permanente Facilities or network providers. Members may self-refer to most Kaiser Permanente specialists.	Any Aetna contracted provider member. No primary care physician selection required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted providers. No primary care physician selection or referrals required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized* charges. You pay the difference between recognized and billed charges.
COVERED EXPENSES				
Acupuncture				
\$15 copay for up to 8 visits per condition per year self-referred. Additional visits when approved by plan.	Paid at 80% after deductible Maximum of 12 visits per calendar year in-and out-of-network combined.	Paid at 60% after deductible	Paid at 100% after \$15 copay All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.	Paid at 60%
Alcohol/Drug Abuse Treatment (inpatient)				
Paid at 100% after \$200 copay per admission	Paid at 80% after \$200 copay	Paid at 60% after deductible	Paid at 90% after \$200 copay	Paid at 60%
Alcohol/Drug Abuse Treatment (outpatient)				
Paid at 100% after \$15 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$15 copay	Paid at 60%
Contraceptives				
For contraceptive drugs and devices, see Prescription Drug benefit	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefit. (See Prescription Drugs.)
Durable Medical Equipment				
Paid at 80% after deductible	Paid at 80% after deductible Breast pump covered at 100% through DME provider	Paid at 60% after deductible	Paid at 90% Breast pump covered at 100% through DME provider	Paid at 60%

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Emergency Medical Care				
➤ Urgent Care Clinic				
Paid at 100% after \$15 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$15 copay (no fee for preventive care)	Paid at 60%
➤ Emergency Room (copays waived if admitted)				
Kaiser Permanente facility: Paid at 100% after \$100 copay Non-Kaiser Permanente facility: Paid at 100% after \$100 copay	Paid at 80% after \$150 copay.	Paid at 80% after \$150 copay. If not emergency, paid at 60% after deductible.	Paid at 90% after \$150 copay	Paid at 90% after \$150 copay. If non-emergency, paid at 60% after copay
➤ Ambulance				
Paid at 80% Kaiser Permanente-initiated non-emergency transfers are paid at 100%	Paid at 80% after deductible when medically necessary. Non-emergency transport must be approved in advance.		Paid at 90% after deductible when medically necessary. Non-emergency transport must be approved in advance.	
Hospital Inpatient				
Paid at 100% after \$200 copay	Paid at 80% after \$200 copay. Physician services paid at 70% if Aexcel specialist not used in specialty areas.	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay. Physician services paid at 80% if Aexcel specialist not used in specialty areas.	Paid at 60% after \$200 copay
Hospital Outpatient				
Paid at 100% after \$15 copay	Paid at 80% after deductible. Physician services paid at 70% if Aexcel specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel specialist is not used in specialty areas.	Paid at 60% after deductible
Hospice				
Paid at 100%	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)				
Paid at 100% after \$200 copay per admission	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay
Maternity Care (prenatal and postpartum)				
Paid at 100% after \$15 copay. Routine care not subject to outpatient services copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 90% after \$15 copay	Paid at 60%

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Mental Health Care (inpatient)				
Paid at 100% after \$200 copay	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay
Mental Health Care (outpatient)				
Paid at 100% after \$15 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$15 copay	Paid at 60% after deductible
Physician Office Visit				
Paid at 100% after \$15 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$15 copay	Paid at 60% after deductible
Prescription Drugs (retail)				
For a 30-day supply: Generic: \$15 copay Brand: \$30 copay Contraceptive drugs and devices are covered in full. Selected preventive over-the-counter drugs covered at 100% in certain situations. Your pharmacy copays will apply to the annual out of pocket maximums.	For a 31-day supply: Generic: 30% coinsurance Brand: 40% coinsurance The minimum coinsurance is \$10, or actual cost of the drug is less. Maximum coinsurance is \$100 per drug.	Not covered	For a 31-day supply: Generic: 30% coinsurance Brand: 40% coinsurance The minimum coinsurance is \$10, or actual cost of the drug is less. Maximum coinsurance is \$100 per drug.	Not covered

Kaiser Permanente	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
	<p>Coinsurance applies to the annual \$1,200 out-of-pocket prescription maximum per person, \$3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment): City pays \$20 per month, participant pays remainder; some over the counter medications are also included. \$5 copay for generic diabetic drugs and supplies, \$15 copay for brand.</p> <p>Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand. Selected preventive over-the-counter drugs covered at 100% in certain situations. Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits.</p>		<p>Coinsurance applies to the annual \$1,200 out-of-pocket prescription maximum per person, \$3,600 per family. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment): City pays \$20 per month, participant pays remainder; some over the counter medications are also included. \$5 copay for generic diabetic drugs and supplies, \$15 copay for brand. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand. Selected preventive over-the-counter drugs covered at 100% in certain situations. Generic oral contraceptives are covered at 100%. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits.</p>	
Prescription Drugs (mail order)				
<p>For a 90-day supply: Generic: \$45 copay Brand: \$90 copay Contraceptive drugs and devices are covered in full. No copay on all smoking cessation drugs through mail order. Your pharmacy copays will apply to the annual out of pocket maximums.</p>	<p>For a 90-day supply: Not covered Generic: 30% coinsurance Brand: 40% coinsurance Minimum is \$20 or double the cost of the drug if less. Maximum is \$200 per drug. Generic oral contraceptives covered at 100%.</p>	<p>For a 90-day supply: Not covered Generic: 30% coinsurance Brand: 40% coinsurance Minimum is \$20 or double the cost of the drug if less. Maximum is \$200 per drug. Generic oral contraceptives covered at 100%.</p>		
Prescription Drugs Annual Out of Pocket Maximum				
Included in annual out-of-pocket maximum	\$1,200 per person \$3,600 per family	Not covered	\$1,200 per person \$3,600 per family	Not Covered

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Preventive Care				
Paid at 100% for adult physical and well child exams and most immunizations and preventive services	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 60% for mammograms, deductible waived. No other preventive services covered.	Paid at 100% Covers adult physical and well child exams, immunizations, digital rectal exams/PSA, colorectal cancer screening	Paid at 60% for well woman care and mammograms. No other preventive services covered.
Rehabilitation Services (inpatient)				
Paid at 100% after \$200 copay per admission. Maximum of 60-days per calendar year for occupational, speech, and physical therapy.	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 100% after \$15 copay 120 days per calendar year for skilled nursing and rehab services in-network and out-of-network combined.	Paid at 60%