

## 2021 Medical Benefits Highlights – I.B.E.W. Local 77

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
<b>Deductible</b> (per calendar year)				
No deductible	\$100 per person \$300 per family	\$150 per person \$450 per family	Does not apply	\$250 per person \$750 per family
<b>Annual Out of Pocket Maximum (OOP Max)</b> includes copays and coinsurance after any applicable deductible. Excludes prescription drug copays				
\$750 per person \$1,500 per family	\$200 per person. \$600 per family	\$1,200 per person. \$3,600 per family	\$500 per person \$1,000 per family	\$3,000 per person \$6,000 per family
<b>Total Annual Out of Pocket Maximum:</b> includes medical copays, coinsurance, and the deductible. Excludes prescription drug copays				
\$750 per person \$1,500 per family	\$300 per person \$900 per family	\$1,350 per person \$4,050 per family	\$500 per person \$1,000 per family	\$3,250 per person \$6,750 per family
<b>Hospital Copay</b>				
None	None	None	None	None
<b>Hospital Pre-admission Authorization</b>				
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	Member responsible for obtaining precertification of out-of-network care
<b>Choice of Providers</b>				
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. No referrals required.	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 provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.

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	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
<b>COVERED EXPENSES</b>				
<b>Acupuncture</b>				
Paid at 100% after \$10 copay. Self-referred up to 8 visits per condition per calendar year. Additional visits when approved by plan.	Paid at 80% after deductible  Maximum of 12 visits per calendar year.	Paid at 60% after deductible	Paid at 100% after \$10 copay  All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.	Paid at 70%
<b>Alcohol/Drug Abuse Treatment (inpatient)</b>				
Paid at 100%	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 100%	Paid at 70%
<b>Alcohol/Drug Abuse Treatment (outpatient)</b>				
Paid at 100% after \$10 copay	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 100% after \$10 copay	Paid at 70%
<b>Contraceptives</b>				
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 benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)	Contraceptive devices and other products covered as medical benefits. (See Prescription Drugs.)
<b>Durable Medical Equipment</b>				
Paid at 80%	Paid at 80% after deductible  Breast pump covered at 100% through DME provider	Paid at 80% after deductible	Paid at 100%  Breast pump covered at 100% through DME provider	Paid at 70%
<b>Emergency Medical Care</b>				
➤ <b>Urgent Care Clinic</b>				
Paid at 100% after \$10 copay	Paid at 80% after deductible	Paid at 80% after deductible	Paid at 100% after \$35 copay	Paid at 70%

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	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
<b>➤ Emergency Room (copays waived if admitted)</b>				
Kaiser Permanente facility: Paid at 100% after \$75 copay Non-Kaiser Permanente facility: Paid at 100% after \$75 deductible	Paid at 80% after deductible	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 100% after \$50 copay	Paid the same as in-network except if it's non-emergency, then it's 70% after \$50 copay
<b>➤ Ambulance</b>				
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 100% when medically necessary. Non-emergency transport must be approved in advance.	
<b>Hospital Inpatient</b>				
Paid at 100%	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%	Paid at 70%
<b>Hospital Outpatient</b>				
Paid at 100% after \$10 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%	Paid at 70%
<b>Hospice</b>				
Paid at 100%	Paid at 90% after deductible		Paid at 100%	Not covered
<b>Maternity Care (delivery &amp; related hospital)</b>				
Paid at 100%	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%	Paid at 70%
<b>Maternity Care (prenatal and postpartum)</b>				
Paid at 100% after \$10 copay. Routine care not subject to outpatient services copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$10 copay	Paid at 70%
<b>Mental Health Care (inpatient)</b>				
Paid at 100%	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$10 copay	Paid at 70%
<b>Mental Health Care (outpatient)</b>				
Paid at 100% after \$10 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$10 copay	Paid at 70%

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<b>Physician Office Visit</b>				
Paid at 100% after \$10 copay	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100% after \$10 copay	Paid at 70%
<b>Prescription Drugs (retail)</b>				
<p>For a 30-day supply:  <b>Generic:</b> \$10 copay.  <b>Brand:</b> \$10 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.</p>	<p>For a 34-day supply or 100 unit supply (whichever is greater):  <b>Generic and brand prescriptions:</b> \$15 copay             Generic oral contraceptives are covered at 100%.            Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefits.            Selected preventive over-the-counter drugs covered at 100% in certain situations.            Non-formulary drugs not covered.</p>	Not covered	<p>For a 31-day supply:  <b>Generic:</b> \$10 copay  <b>Preferred brand:</b> \$10 copay  <b>Non-preferred drugs:</b> \$40 copay            Generic oral contraceptives are covered at 100%.            Contraceptive devices and other prescription contraceptive products are covered under the medical benefit. Select preventive over-the-counter drugs covered at 100% in certain situations.</p>	Not covered
<b>Prescription Drugs (mail order)</b>				
<p>For a 90-day supply:            Generic: \$30 copay            Brand: \$30 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>90 day or 100 units, whichever is greater:            Generic and brand prescriptions: \$30 copay            Non-formulary drugs are not covered. Generic oral contraceptives covered at 100%</p>	Not covered	<p>For a 90-day supply:  <b>Generic:</b> \$20 copay  <b>Preferred brand:</b> \$40 copay  <b>Non-preferred drugs:</b> \$80 copay            Generic oral contraceptives are covered at 100%</p>	Not covered

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<b>Prescription Drugs Annual Out of Pocket Maximum</b>				
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
<b>Preventive Care</b>				
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 70% for well woman care and mammograms. No other preventive services covered.
<b>Rehabilitation Services (inpatient)</b>				
Paid at 100%  Maximum of 60 days per calendar year for occupational, speech, and physical therapy.	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%  120 days per calendar year for skilled nursing and rehab services in-network and out-of-network combined.	Paid at 70%
<b>Rehabilitation Services (outpatient)</b>				
Paid at 100% after \$10 copay Maximum of 60 visits per calendar year for occupational, speech, and physical therapy.	Paid at 80% after deductible Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of 30 visits for all services combined (physical/massage, speech, occupational and cardiac/pulmonary therapy).	Paid at 80% after deductible	Paid at 100% after \$10 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.	Paid at 70%
<b>Skilled Nursing Facility</b>				
Paid at 100%; 60-day maximum per calendar year	Paid at 80% after deductible  Maximum of 90 days per calendar year	Paid at 80% after deductible	Paid at 100%  Maximum of 120 days per calendar year for in-network and out-of-network combined	Paid at 70%

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<b>Smoking Cessation</b>				
Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs through mail-order.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Only covers counseling	Only covers counseling
<b>Spinal Manipulations</b>				
Paid at 100% after \$10 copay. Self-referral to Kaiser Permanente-designated providers. Must meet Kaiser Permanente protocol. Maximum of 10 visits per calendar year.	Paid at 80% after deductible Maximum of 10 visits per year for in-network and out-of-network combined	Paid at 80% after deductible	Paid at 100% after \$10 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined	Paid at 70%
<b>Sterilization Procedures</b>				
Inpatient: Paid at 100% Outpatient: Paid at 100% after \$10 copay Women's sterilization procedures covered in full	Paid at 80% after deductible	Paid at 60% after deductible	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$10 copay.	Paid at 70%
<b>Tooth Injury/Oral Surgery (due to accident)</b>				
Inpatient: Paid at 100% Outpatient: Paid at 100% after \$10 copay Oral Surgery requires pre-authorization	Paid at 80% after deductible	Paid at 80% after deductible	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$10 copay.	Paid at 70%
<b>Vision Exam/Hardware</b>				
Exam: Paid at 100% after \$10 copay. One exam every 12 months. Hardware: Not included	Covered under VSP		Covered under VSP	
<b>X-ray and Lab Tests (Outpatient)</b>				
Paid at 100%	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%	Paid at 70%

\*Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

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