# 2023 PEBB medical benefits comparison

Washington State Health Care Authority
PUBLIC EMPLOYEES BENEFITS BOARD

Use the following charts to 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. Some 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 specific benefit information, including preauthorization requirements and exclusions. If anything in these tables conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

| What you pay | Managed Care and Health Management Organization (HMO) 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<br>$900/family | $1,500/person<br>$3,000/family | $175/person<br>$525/family | $125/person<br>$375/family | $250/person<br>$750/family | $1,500/person<br>$3,000/family |
| Medical out-of-pocket limit | $2,500/person<br>$5,000/family | $5,100/person<br>$10,200/family | $2,000/person; $4,000/family | | $3,000/person<br>$6,000/family | $5,100/person<br>$10,200/family |
| Prescription drug deductible | None | Combined with medical deductible | $100/person; $300/family<br>(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 | 15% | | 20%[1] | | | 10% |
| Emergency room | | | $250 | $75 + 15% | $300 | |
| **Hearing services** | | | | | | |
| Hearing aids | $0[1]<br>one per ear every 60 months | $0[1]<br>one per ear every 60 months | $0[1]<br>one per ear any consecutive 60 months | | | $0<br>one per ear any consecutive 60 months |
| Routine annual hearing exam | $35[1] | $30 | $15 ($30[1]) | $0 (15%[2]) | $30 ($50[2]) | 10% |

1. Deductible waived.
2. Specialist copay/coinsurance.

| What you pay | Preferred Provider Organization (PPO) Plans | | | |
|---|---|---|---|---|
| | Uniform Medical Plan[1] | | | |
| | Classic | Plus | Select | CDHP |
| **Annual costs** | | | | |
| **Medical deductible** | $250/person<br>$750/family | $125/person<br>$375/family | $750/person<br>$2,250/family | $1,500/person<br>$3,000/family |
| **Medical out-of-pocket limit** | $2,000/person<br>$4,000/family | | $3,500/person<br>$7,000/family | $4,200[2]/person<br>$8,400[2]/family |
| **Prescription drug deductible** | $100[3]/person;<br>$300[3]/ family | None | $250[3]/person;<br>$750[3]/ family | Combined with medical deductible |
| **Prescription drug out-of-pocket limit** | $2,000/person; $4,000/family | | | Combined with medical out-of-pocket limit[2] |
| **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)[4] | | | $0 (one per ear every 5 years) |
| **Routine annual hearing exam** | $0[4] | | | 15% |

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1. Administered by Regence BlueShield and Washington State Rx Services.
2. Not to exceed $7,000/member.
3. Applies to Tier 2 and specialty only, except covered insulins.
4. Deductible waived.

| What you pay | Managed Care and Health Management Organization (HMO) Plans | | | | | |
|---|---|---|---|---|---|---|
| | Kaiser Foundation Health Plan of the Northwest | | Kaiser Foundation Health Plan of Washington | | | |
| | Classic[1] | 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[2] | $20[2] | $15 | $0 | $30 | 10% |
| Preventive care (deductible waived) | $0 | | $0 | | | |
| Primary care | $25[2] | $20[2] | $15 | $0 | $30 | 10% |
| Specialist | $35 | $30 | $30 | 15% | $50 | |
| Telemedicine/virtual care | $0 | | $0 | | | |
| Urgent care | $45 | $40 | $15 ($30[3]) | 15%[3] | $30 ($50[3]) | 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 ($30[3]) (10 visits/year) | $0 (15%[3]) (10 visits/year) | $30 ($50[3]) (10 visits/year) | 10% (10 visits/year) |
| Massage therapy | $25 (Self-referred: 12 visits/year) | | $30[3] (60 combined therapy visits/ year) No NDT limit | 15%[3] (16 separate visits/year) | $50[3] (60 combined therapy visits/ year) No NDT limit | 10%[3] (60 combined therapy visits/ year) No NDT limit |
| Physical, occupational, speech, and neurodevelopmental therapy (NDT) | $35 (60 combined visits/year) | $30 (60 combined visits/year) | | 15%[3] (60 combined visits/year) No NDT limit | | |
| **Vision care** | | | | | | |
| Glasses and contact lenses | Any amount over $150 every 2 years[4] | | Any amount over $150 every 24 months[4] | | | |
| Routine annual eye exam | $25 | $20 | $15 ($30[3]) | $0 (15%[3]) | $30 ($50[3]) | 10% |

1. Deductible waived for KPNW Classic copays.
2. $0 ages 17 and under.
3. Specialist copay/coinsurance. Deductible waived for SoundChoice.
4. Includes contact lens fitting fee.

| What you pay | Preferred Provider Organization (PPO) Plans | | | |
|---|---|---|---|---|
| | Uniform Medical Plan[1] | | | |
| | Classic | Plus | Select | CDHP |
| **Hospital care** | | | | |
| **Inpatient** | $200/day up to $600<br>15% professional services, 0% for behavioral health | | $200/day up to $600<br>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 | | | |

1. Administered by Regence BlueShield and Washington State Rx Services.

# 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 and you pay no more than $35 per 30-day supply for covered insulins.

| 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 | | | N/A | $10 | | | N/A |
| 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[1] | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **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 | | | 15%; Insulins 5% up to $10 | 5% up to $30 | | | 15%; Insulins 5% up to $30 |
| **Tier 1 (**Primarily low-cost generic) | 10% up to $25 | | | 15%; Insulins 10% up to $25 | 10% up to $75 | | | 15%; Insulins 10% up to $75 |
| **Tier 2** (Preferred brand-name drugs and high-cost generic) | 30% up to $75; Insulins 30% up to $35 | | | 15%; Insulins 30% up to $35 | 30% up to $225; Insulins 30% up to $105 | | | 15%; Insulins 30% up to $105 |

1. Administered by Regence BlueShield and Washington State Rx Services.