2023 Medical Plan Cost Comparison

Flex Dollars and Premiums	EE Only	EE + Sp	EE + Ch	Family
Flex + HCS Provided to employee	**$10,199**	**$19,194**	**$17,107**	**$26,125**
Kaiser WA Classic Premium	$10,976	$21,099	$18,569	$28,692
Kaiser WA Value Premium	$10,106	$19,360	$17,046	$26,300
*Kaiser WA CDHP Premium	$9,336	$17,798	$15,857	$23,619
Uniform Medical Classic Premium	$10,601	$20,350	$17,913	$27,662
Uniform Medical Select Premium	$9,687	$18,521	$16,312	$25,147
*Uniform Medical CDHP Premium	$9,390	$17,907	$15,952	$23,769
**Portion of CDHP premium deposited into HSA, if CDHP elected*	*$700*	*$1,400*	*$1,400*	*$1,400*

Member Costs	Kaiser WA Classic	Kaiser WA Value	Kaiser WA CDHP	Uniform Medical Classic	Uniform Medical Select	Uniform Medical CDHP
Deductible	$175/person	$250/person	$1,500/individual only	$250/person	$750/person	$1,500/individual only
	$525/family	$750/family	$3,000/family (EE+1 or more dependents)	$750/family	$2,250/family	$3,000/family (EE+1 or more dependents
Out-of-pocket maximum	$2,000/person	$3,000/person	$5,100 individual/ $10,200 family (EE+1 or more must meet family out-of-pocket max before plan pays 100%)	$2,000/person	$3,500/person	$4,200 individual/ $8,400 family ($6,900 per person in a family)
	$4,000/family	$6,000/family		$4,000/family	$7,000/family	
Prescription drug deductible (Tier 2 and Tier 3 only)	$100/person, $300/family	$100/person, $300/family	Included in deductible/ Out of pocket max	$100/person, $300/family Deductible (Tier 2 & specialty)	$250/person, $750/family Deductible (Tier 2 & specialty)	Included in deductible/ Out of pocket max
Prescription drug out-of-pocket maximum	$2,000/person, $8,000/family, in addition to medical out-of-pocket max			$2,000/person, $4,000/family, in addition to medical out-of-pocket max		
Ambulance - Per trip, air or ground	20%		10%	20%	20%	20%
Diagnostic tests, labs and x-rays	$0; MRI/CT/PET scan $30	$0; MRI/CT/PET scan $50		15%	20%	15%
Durable medical equipment, supplies, and prostheses	20%			15%	20%	15%
ER (Copay waived if admitted)	$250	$300		$75 copay + 15%	$75 copay + 20%	15%
Hearing - Hardware	$0, 1 per ear every 60 months			$0, 1 per ear every 60 months		
Hearing - Routine annual exam	$15 - $30	$30 - $50	10%	$0	20%	15%
Home health	$0			15%	20%	15%
Hospital services - Inpatient	$150/day; $750 max/admission	$250/day; $1250 max/admission		$200/day; $600 max/year + 15% professional fees	$200/day; $600 max/year + 20% professional fees	15%
Hospital services - Outpatient	$150	$200		15%	20%	15%
Obstetric care - Inpatient	$150/day; $750 max/admission	$250/day; $1250 max/admission				
Office visit - Chemotherapy/Radiation	$30	$50	10%	15%	20%	15%
Office visit - Behavioral health	$15	$30		15%	20%	15%
Office visit - Primary care	$15	$30		15%	20%	15%
Office visit - Urgent care	$15-$30	$30-$50		15%	20%	15%
Office visit - Specialist	$30	$50		15%	20%	15%
Office visit - Telemed/virtual care	$0	$0	0%	Varies, see certificate of coverage		
Office visit - Preventative	$0	$0	0%	0%	0%	0%
Neurodevelopmental therapy (Per-visit cost; no limit; Kaiser: pre-auth required)	$30	$50	10%	$15	$15	15%
Physical, occupational and speech therapy (Per-visit cost; 60 max/yr combined; Kaiser: pre-auth required)	$30	$50	10%	$15	$15	15%
Acupuncture (12 visit max/yr)	$15	$30	10%	15% (24 visit max)	20% (24 visit max)	15% (24 visit max)
Spinal manipulations (10 visit max/yr)	$15	$30	10%	15% (24 visit max)	20% (24 visit max)	15% (24 visit max)

Read the plan's Certificate of Coverage for full coverage details on each benefit and for details on more specialized benefits not listed above.

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Member Costs	Kaiser WA Classic	Kaiser WA Value	Kaiser WA CDHP	Uniform Medical Classic	Uniform Medical Select	Uniform Medical CDHP
Vision care - Exam (annual)(subject to deductible)	Preventative: $0; Other $15	Preventative: $0; Other $30	10%	$0	$0	$0
Vision care - Glasses and contact lenses (not subject to deductible)	Under 19, allowed 1 pair of frames and lenses per year or contacts covered at 50%; Age 19 and over, any amount over $150 every 24 months.			Any amount over $150 every two calendar years for frames, lenses, and elective contacts. Contacts and fitting fees $30. Hardware covered in full yearly for children through age 18.		

Additional Information

UMP members who see an out-of-network provider will pay 40% of the UMP allowed amount plus the amount which exceeds UMPs allowed amount. Does not apply to out-of-pocket max.
UMP: All co-insurance payments count toward annual out-of-pocket maximum, except Rx and except out-of-network
2023 HSA maximum contribution: Individual - $3,650; Family $7,750. Age 55+ can contribution an additional $1000

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

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	**Select**	**CDHP**	**Classic**	**Select**	**CDHP**
Value (High value Rx for chronic conditions)	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 $25
Tier 2 (Preferred brand-name drugs and high-cost generic)	30% up to $75;		15%	30% up to $225;		15%;
	Insulins 30% up to $35			Insulins 30% up to $105		

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

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2023

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Non-preferred generic and brand-name	$40	$50	$40	$80	$100	$80
Preferred specialty	50% up to $250	50%	50% up to $250	50% up to $750	50%	50% up to $750
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