Washington State Health Care Authority
Public Employees Benefits Board

2017 Medicare Plan Benefits Comparison

The chart below briefly compares the per-visit costs of some in-network benefits for PEBB plans. Some copays and coinsurance do not apply until after you have paid your annual deductible. Call the plans directly for more information on specific benefits, including preauthorization requirements and exclusions. Group Health and Kaiser Permanente offer Medicare Advantage plans, but not in all areas. If you are in an area where a Medicare Advantage plan is not available, your plan will enroll you in its Medicare coordination plan.

Annual Costs	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Medical deductible	$0	$250/person $750/family	$0	$250/person $750/family
Medical out-of-pocket limit[1] (See separate prescription drug out-of-pocket limit for UMP Classic)	$2,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	$2,000/person Your medical deductible, copays, and coinsurance for all covered services apply.	$1,500/person Your copays and coinsurance for most covered services apply (except prescription drug costs).	$2,500/person $5,000/family Your medical deductible, copays, and coinsurance for most covered services apply.
Prescription drug deductible	None	None	None	$100/person $300/family (Tier 2 and 3 drugs only)
Prescription drug out-of-pocket limit[1]	None	Prescription copays and coinsurance apply to the medical out-of-pocket limit.	None	$2,000/person Your prescription drug deductible and coinsurance for all covered prescription drugs apply.

[1] Premiums, charges for services in excess of a benefit, charges in excess of the plan's allowed amount, coinsurance for out-of-network providers (UMP Classic), and charges for non-covered services do not apply to the out-of-pocket limits. Non-covered services include, but are not limited to, member costs above the vision and hearing aid hardware maximums.

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Ambulance Per trip, air or ground	$150	20%	$50	20%
Diagnostic tests, laboratory, and x-rays	$0	$0 MRI/CT/PET scan $30	$0	15%
Durable medical equipment, supplies, and prosthetics	20%	20%	$0	15%
Emergency room Copay waived if admitted	$65	$250	$50	$75 + 15%
Hearing Routine annual exam	$20	$15	$30	$0
Hardware	You pay any amount over $800 every 36 months after deductible has been met for hearing aid and rental/repair combined.			You pay amount over $800 every three calendar years for hearing aid and rental/repair combined.

(continued)

Benefits	Group Health Medicare Plan		Kaiser Permanente Senior Advantage	UMP Classic
	Medicare Advantage	Original Medicare (coordinates with Medicare)		Medicare
	You pay		You pay	You pay
Hospital services Inpatient	$200/day for the first 5 days, up to $1,000 maximum/ admission	$150/day, up to $750 maximum/ admission	$500/admission	$200/day, up to $600 maximum/ admission + 15% professional fees
Outpatient	$200	$150	$50	15%
Office visit				
Primary care	$20	$15	$30	15%
Urgent care	$20	$15	$35	15%
Specialist	$20	$30	$30	15%
Mental health	$20	$15	$30	15%
Chemotherapy	$0	$15	$0	15%
Radiation	$0	$30	$0	15%
Physical, occupational, and speech therapy	$20	$30 (Per-visit cost for 60 visits/year combined)	$30	15%
Prescription drugs				
Retail pharmacy (up to a 30-day supply) — includes Medicare-approved diabetic disposable supplies				
Value tier	—	$5	—	5% up to $10
Tier 1	$20	$20	$20	10% up to $25
Tier 2	$40	$40	$40	30% up to $75
Tier 3	50% up to $250	50% up to $250	—	50%
Mail order (up to a 90-day supply)				
Value tier	—	$10	—	5% up to $30
Tier 1	$40	$40	$40	10% up to $75
Tier 2	$80	$80	$80	30% up to $225
Tier 3	50% up to $750	50% up to $750	—	50% (up to $150 for specialty drugs; no per-prescription cost-limit for non-specialty drugs)
Preventive care	$0	$0	$0	$0
	See certificate of coverage or check with plan for full list of services.			
Spinal manipulations	$20	$15	$30	15%
Vision care[2]				
Exam (annual)	$20	$15	$30	$0 You pay any amount over $65 for contact lens fitting fees.
Glasses and contact lenses	You pay any amount over $150 every 24 months (or two calendar years for UMP) for frames, lenses, and contacts combined.)			

[2] Contact your plan about copays and limits for children's vision care.

The information in this document is accurate at the time of printing.
Please contact the plans or review the certificate of coverage before making decisions.