MEDICAL PLAN COMPARISON CHART

Plan Features	Qualified High Deductible Health Plan (HDHP) with HSA		PPO with HRA	HMO with HRA
Carrier	Premera Blue Cross	Kaiser Permanente*	Premera Blue Cross	Kaiser Permanente*
In-network Deductible (Individual / Family)	$1,600 / $3,200	$1,600 / $3,200	$750 / $1,500	$0 / $0
Non-Network Deductible (Individual / Family)	$3,200 / $6,400	N/A	$1,500 / $3,000	N/A
Deductible Embedded / Non-Embedded**	Non-Embedded	Non-Embedded	Embedded	N/A
In-network Out-of-Pocket Maximum (Individual / Family)	$4,000 / $8,000	$4,000 / $8,000	$3,000 / $6,000	$3,750 / $7,500
Non-Network Out-of-Pocket Maximum (Ind / Fam)	Unlimited	N/A	Unlimited	N/A
Annual HSA Contribution (Individual / Family)	Up to $850 / $1,700	Up to $850 / $1,700	N/A	N/A
Annual HRA Contribution (Individual / Family)	N/A	N/A	$500 / $1,000	$500 / $1,000
Coinsurance (In-network / Out-of-network)	80% / 50%	80% / 0%	80% / 50%	80% / 0%
Preventive Care	100%	100%	100%	100%
Primary Care Office Visit	80%	80%	$35 Copay (dw)†	$25 Copay
Specialist Office Visit	80%	80%	$50 Copay (dw)	$40 Copay
Walk-In / Urgent Care Visit	80%	80%	$50 Copay (dw)	$25 Copay
Emergency Room	80%	80%	$150 Copay / 80%	$200 Copay, 80%
Outpatient Lab / X-Ray	80%	80%	80%	80%
Therapy (MT, PT, etc.)†	80%	80% (up to 60 visits)	$35 Copay (dw)	$25 Copay
Prescription Drugs				
Retail / Mail Order Copays (Typically 90 day supply)				
Preventive	100% / 100%	100% / 100%	100% / 100%	100% / 100%
Preferred Generic	10% / 10%	20% / 20%	$10 / $20 (dw)	$10 / $30
Preferred Brand	20% / 20%	20% / 20%	$35 / $70 (dw)	$35 / $105
Specialty	20% / 20%	20% / 20%	$60 / $60 (dw)	$60 / $180
Non-Preferred	50% / 50%	Not Covered	50% / 50% (dw)	Not Covered

* Kaiser Permanente – Must use a Kaiser Permanente facility or partner for services to be considered in-network (except emergencies). Only Washington state employees are eligible to enroll in Kaiser Permanente.

** Embedded – there are two deductible amounts within one plan, single and family. Non-Embedded – the plan does not begin to pay for medical expenses until the entire deductible has been met.

† (dw) Deductible Waived, (MT) Massage Therapy, (PT) Physical Therapy.

EMPLOYEE CONTRIBUTIONS FOR MEDICAL AND DENTAL COVERAGE

The following chart represents your bi-weekly contribution based on which plan you elect, your annual salary, and how many dependents you cover. Contributions will be deducted from your pay on a before-tax basis. This chart does not include Wellness Incentives or the Spouse Surcharge.

	QHDHP w/ HSA		PPO	HMO
Expected Annual Earnings	Premera Blue Cross	Kaiser Permanente	Premera Blue Cross	Kaiser Permanente
Less than $35,000*				
Employee	$ 58.40	$ 41.22	$ 82.44	$ 75.57
Employee + Spouse	$ 130.89	$ 113.20	$ 179.71	$ 160.61
Employee + Child(ren)	$ 91.15	$ 73.32	$ 133.68	$ 118.26
Employee + Family	$ 175.00	$ 156.38	$ 252.32	$ 231.83
$35,000 - $54,999*				
Employee	$ 63.33	$ 44.70	$ 88.66	$ 81.58
Employee + Spouse	$ 142.64	$ 123.36	$ 193.75	$ 173.98
Employee + Child(ren)	$ 99.08	$ 79.71	$ 143.64	$ 127.71
Employee + Family	$ 190.39	$ 170.14	$ 271.11	$ 250.52
$55,000 - $74,999*				
Employee	$ 70.51	$ 49.77	$ 97.05	$ 90.00
Employee + Spouse	$ 158.96	$ 137.48	$ 211.29	$ 191.57
Employee + Child(ren)	$ 110.59	$ 88.97	$ 156.59	$ 140.68
Employee + Family	$ 213.19	$ 190.51	$ 295.95	$ 276.71
$75,000 - $99,999*				
Employee	$ 80.12	$ 56.55	$ 108.39	$ 101.32
Employee + Spouse	$ 180.79	$ 156.36	$ 235.03	$ 215.24
Employee + Child(ren)	$ 125.91	$ 101.29	$ 174.02	$ 158.04
Employee + Family	$ 243.50	$ 217.59	$ 329.31	$ 311.68
$100,000 - $124,999*				
Employee	$ 89.61	$ 63.25	$ 119.12	$ 112.27
Employee + Spouse	$ 202.40	$ 175.05	$ 257.21	$ 238.01
Employee + Child(ren)	$ 141.15	$ 113.55	$ 190.30	$ 174.77
Employee + Family	$ 273.71	$ 244.59	$ 360.37	$ 345.46
$125,000 – 149,999*				
Employee	$ 100.05	$ 70.63	$ 130.66	$ 124.18
Employee + Spouse	$ 226.21	$ 195.64	$ 280.87	$ 262.71
Employee + Child(ren)	$ 157.94	$ 127.06	$ 207.60	$ 192.90
Employee + Family	$ 307.16	$ 274.48	$ 393.43	$ 382.19
Over $150,000 *				
Employee	$ 104.06	$ 73.45	$ 135.88	$ 129.15
Employee + Spouse	$ 235.26	$ 203.47	$ 292.10	$ 273.22
Employee + Child(ren)	$ 164.26	$ 132.15	$ 215.90	$ 200.61
Employee + Family	$ 319.45	$ 285.47	$ 409.17	$ 397.48

Dental Coverage – Bi-weekly contribution			
Employee Only	Employee & Spouse	Employee & Child(ren)	Employee & Family
$6.50	$13.00	$13.50	$20.00