Fred Hutchinson Cancer Center

Comparing Your Health Plans
July 1, 2022

Health Care Options

The following table summarizes your health plan options. The calendar year deductible applies unless otherwise noted.

Plan Feature	Premera Plan A – Heritage		Premera Plan B – Heritage Prime		Kaiser Permanente HMO Plan
	Network Provider (**Includes** access to Swedish, Providence, CHI Franciscan, VM, Everett Clinic and more)	Non-Network Provider	Network Provider (**Excludes** Swedish, Providence, CHI Franciscan, includes VM and Everett Clinic)	Non-Network Provider	Core Network (Kaiser Permanente)
Calendar year deductible *-Per person* *-Per family*	(deductible waived for office visits) $450 $1,350	 $650 $1,950	(deductible waived for office visits) $450 $1,350	 $650 $1,950	 None None
Calendar year out-of-pocket maximum *-Per person* *-Per family*	(including deductible, copays with some exceptions) $1,750 $5,250	(including deductible, copays with some exceptions) $4,000 $12,000	(including deductible, copays with some exceptions) $1,750 $5,250	(including deductible, copays with some exceptions) $4,000 $12,000	(including copays) $1,500 $3,000
Lifetime maximum	Unlimited		Unlimited		Unlimited
Preventive care (e.g., well-child/well-adult office visits, immunizations)	Covered in full	Not covered	Covered in full	Not covered	Covered in full
Office visits	100% after $25 copay per visit	70% of allowable charge	100% after $25 copay per visit	70% of allowable charge	100% after $25 copay per visit
Outpatient services (e.g., outpatient surgery and therapies)	90% of allowable charge	70% of allowable charge	90% of allowable charge	70% of allowable charge	100% after $25 copay per visit
Lab test and x-ray services	90% of allowable charge	70% of allowable charge	90% of allowable charge	70% of allowable charge	100%
Hospital care	90% of allowable charge	70% of allowable charge	90% of allowable charge	70% of allowable charge	100%
Emergency care	90% after $150 copay per emergency visit, copay waived if admitted		90% after $150 copay per emergency visit, copay waived if admitted		100% after $150 copay per emergency visit, copay waived if admitted

Plan Feature	Premera Plan A - Heritage		Premera Plan B – Heritage Prime		Kaiser Permanente HMO Plan
	Network Provider (**Includes** access to Swedish, Providence, CHI Franciscan, VM, Everett Clinic and more)	Non-Network Provider	Network Provider (**Excludes** Swedish, Providence, CHI Franciscan, includes VM and Everett Clinic)	Non-Network Provider	Core Network (Kaiser Permanente)
Prescription drugs (some prescriptions may require preauthorization)	Preferred Generic/Preferred Brand/Preferred Specialty/Non-Preferred all drugs: $10/$30/$50/30% per prescription Retail: 1 copay per 30-day supply Mail Order: 2x copay 90-day supply (No Specialty Mail Order) Non-participating pharmacy: Plan pays 60% after the applicable cost share		Preferred Generic/Preferred Brand/Preferred Specialty/Non-Preferred all drugs: $10/$30/$50/30% per prescription Retail: 1 copay per 30-day supply Mail Order: 2x copay 90-day supply (No Specialty Mail Order) Non-participating pharmacy: Plan pays 60% after the applicable cost share		Preferred Generic/ Preferred Brand/ Non-Preferred copays: $10/$30/$50 per prescription Retail: 1 copay per 90-day supply (specialty drugs 30-day supply) Mail Order: 2x copay per 90-day supply
Mental health services *-Inpatient* *-Outpatient*	90% of allowable charge Subject to office visit copay	70% of allowable charge	90% of allowable charge Subject to office visit copay	70% of allowable charge	100% Subject to office visit copay
Vision coverage *-Exam* - 1 per year *-Hardware (eyeglasses or contacts)* - 1 per year	100% after $25 copay Hardware up to $150 Members under 19 Hardware covered at 100%	70% of allowable charge after deductible Members under 19 Exam paid at 100% after $25 copay Hardware allowance shared with in-network	100% after $25 copay Hardware up to $150 Members under 19 Hardware covered at 100%	70% of allowable charge after deductible Members under 19 Exam paid at 100% after $25 copay Hardware allowance shared with in-network	100% after $25 copay Hardware up to $150 Members under 19 Frames and lenses paid at 100% or 50% for contacts
Alternative Medicine (combined 60 visits per calendar year - acupuncture, chiropractic and massage visits)	100% after $25 copay	70% of allowable charge	100% after $25 copay	70% of allowable charge	100% after $25 copay
Cancer treatment at SCCA	Deductible, copay and coinsurance waived for cancer screening and treatment services	N/A – SCCA is In-Network	Deductible, copay and coinsurance waived for cancer screening and treatment services	N/A – SCCA is In-Network	$25 copay for services **after** active cancer diagnosis by Kaiser, Preauthorization needed for some services (see booklet)