

# 2019 Medical Plan Quick Comparison: Transit ATU 587 Employees

Plan Feature (In-network)	SmartCare Gold (Kaiser)	KingCare Select (Regence & CVS)	KingCare Gold (Regence & CVS)
<b>Provider Choice</b>	A primary care provider coordinates care through the plan network. You may self-refer to many Kaiser specialists. No coverage for out-of-network care unless approved/referred.	A primary care doctor helps you coordinate your care within your network. Referrals are not required. You save the most by staying in-network, but you can go out-of-network for a higher cost.	You may choose any qualified provider, but your out-of-pocket costs are lowest when you use network providers.
<b>Out-of-area coverage</b>	See next page.	See next page.	See next page.
<b>Benefit Access Fee</b>	\$75 per month	\$75 per month	\$150 per month
<b>Deductible<sup>1</sup></b>	Single \$0 Family \$0	Single \$250 Family \$750	Single \$350 Family \$1,050
<b>Out-of-Pocket Limit<sup>2</sup></b>	Single \$1,000 Family \$2,000	Single \$1,250 Family \$2,750	Single \$1,350 Family \$3,050
<b>Prescription Out-of-Pocket Limit</b>	Single & Family \$0 Copays apply to out of pocket maximum	Single \$1,500 Family \$3,000	Single \$1,500 Family \$3,000
<b>Your cost—after deductible—using in-network providers<sup>3</sup></b>			
<b>Emergency Room</b>	\$100 copay	10% after \$200 copay	15% after \$175 copay
<b>Hospital–Inpatient</b>	\$200 copay	10%	15%
<b>Labs, X-ray, Tests</b>	0%	10%	15%
<b>Mental Health</b>	Outpatient: \$20 copay Inpatient: \$200 copay	Outpatient therapy services: \$20 copay Outpt non-therapy services & inpt services: 10%	15%
<b>Office Visits</b>	\$20 copay	\$25 (no deductible)	15%
<b>Prescription Drugs (retail 30-day supply)</b>	Generic: \$10 copay Preferred brand: \$20 copay Non-preferred brand: \$30 copay	Generic: \$5 copay Preferred brand: \$25 copay Non-preferred brand: \$75 copay	Generic: \$8 copay Preferred brand: \$33 copay Non-preferred brand: \$67 copay
<b>Urgent Care</b>	\$20 copay	10%	15%

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**DISCLAIMER:** This chart should be used as a general guide only. For specific plan details, refer to the governing documents at [KingCounty.gov/Plan-Details](http://KingCounty.gov/Plan-Details).

1. Deductible: The amount you pay per year before the plan begins to pay.
2. Out-of-pocket limit: The most you could pay per year for your share of the costs of covered services, including the deductible, copays, and coinsurance.
3. All services must be medically necessary. See plan guide for details, limits, restrictions, and preauthorization requirements.

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# 2019 Out-of-Network Coverage: Transit ATU 587 Employees

Plan Feature (Out-of-network)	SmartCare Gold (Kaiser)	KingCare Select (Regence & CVS)	KingCare Gold (Regence & CVS)
<b>Out-of-Area Coverage</b>	Covered care is available at out-of-area Kaiser Permanente facilities—call Member Services to set up access. No coverage for out-of-network care unless approved/referred. If outside the Kaiser area, urgent and emergency care is covered at any provider.	When seeking care outside your network, covered services are reimbursed at the out-of-network benefit level, which is significantly lower. Emergency care is covered the same anywhere.	Same coverage as when home, through Regence and CVS Caremark® national provider networks. Your out-of-pocket costs are lowest when you use network providers. Emergency care is covered the same anywhere.
<b>Deductible<sup>1</sup></b>	Single \$0 Family \$0	Single \$500 Family \$1,500	Single \$350 Family \$1,050
<b>Out-of-Pocket Limit<sup>2</sup></b>	Single \$1,000 Family \$2,000	Single \$2,500 Family \$5,500	Single \$2,350 Family \$5,050
<b>Emergency Room</b>	\$100 copay	10% after \$200 copay	15% after \$175 copay
<b>What you pay for most covered services<sup>3</sup></b>	100% (Plan pays 0%)	40% after deductible & copays, until you reach the out-of-pocket limit. (Plan pays 60%.)	35% after deductible & copays, until you reach the out-of-pocket limit. (Plan pays 65%.)

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2. Out-of-pocket limit: The most you could pay per year for your share of the costs of covered services, including the deductible, copays, and coinsurance.
3. All services must be medically necessary. See plan guide for details, limits, restrictions, and preauthorization requirements.