

# 2025 SEBB Medical Benefits At-A-Glance

Use the following charts to view the deductibles, out-of-pocket limits, per-visit out-of-pocket costs, and prescription drug costs for SEBB medical plans.

You must pay your annual deductible before most coinsurance (%) applies, unless noted that the deductible is waived. The deductible does not apply to most copays (\$), unless enrolled in UMP High Deductible. You must pay the deductible first for most covered services before copays or coinsurance apply to UMP High Deductible.

Some costs are separate for single subscribers and families. These costs are shown in order as individual/family.

Benefits and visit limits listed as per year are based on calendar years (January 1 through December 31). Call the plans directly for specific benefit information, including preauthorization requirements and exclusions. If anything in these charts conflicts with the plan's benefits booklet (also called evidence of coverage or certificate of coverage), the benefits booklet takes precedence and prevails.

**Note:** Some benefits include symbols to represent additional information that is described on the next page.

*Continued on next page* →

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans							
	Kaiser Permanente NW			Kaiser Permanente WA				Premera
	Plan 1	Plan 2	Plan 3	Core 1	Core 2	Core 3	SoundChoice	HMO
<b>Annual costs (individual/family)</b>								
Medical deductible	\$1,250/ \$2,500	\$750/ \$1,500	\$125/ \$250	\$1,250/ \$3,750	\$750/ \$2,250	\$250/ \$750	\$125/ \$375	\$750/ \$1,500
Medical out-of-pocket limit	\$4,500/ \$9,000	\$4,000/ \$8,000	\$2,500/ \$5,000	\$4,000/ \$8,000	\$3,000/ \$6,000	\$2,000/ \$4,000		\$3,500/ \$7,000
Prescription drug deductible	None			None				None
Prescription drug out-of-pocket limit	Combined with medical limit			Combined with medical limit				Combined with medical limit
<b>Emergency services</b>								
Ambulance	20%			20%*				20%
Emergency room				\$150 + 20%			\$150 + 15%	\$150 + 20%‡
<b>Hearing services</b>								
Hearing aids (per ear)	Any amount over \$3,000 every 36 months			Any amount over \$3,000 every 36 months*				Any amount over \$3,000 every 36 months*
Routine annual hearing exam	\$40*	\$35*	\$30*	\$30 (\$40#) + 20%	\$25 (\$35#) + 20%	\$20 (\$30#) + 20%	\$20 (\$30#) + 15%	\$0*

Kaiser Foundation Health Plan of the Northwest offers plans in Clark and Cowlitz counties in Washington and select counties and ZIP codes in Oregon.

Uniform Medical Plan (UMP) is administered by Regence BlueShield ArrayRx, formerly known as Washington State Rx Service.

**Some benefits include symbols to represent additional information as described below:**

- \* Deductible is waived
- # Specialist copay/coinsurance
- † Applies to Tier 2 drugs only, except covered insulins
- ‡ See additional terms and conditions listed in the plan's benefits booklet
- ▲ Out-of-pocket limit not to exceed \$7,000 per member

What you pay ↘	Preferred Provider Organization (PPO) Plans								
	Kaiser Permanente WA Options			Premera		Uniform Medical Plan			
	Summit PPO 1	Summit PPO 2	Summit PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible

**Annual Costs** (individual/family)

Medical deductible	\$1,250/ \$2,500	\$750/ \$1,500	\$250/ \$500	\$750/ \$1,875	\$1,250/ \$3,125	\$750/ \$2,250	\$250/ \$750	\$125/ \$375	\$1,650/ \$3,300
Medical out-of-pocket limit	\$4,500/ \$9,000	\$3,500/ \$7,000	\$2,500/ \$5,000	\$3,500/ \$7,000	\$5,000/ \$10,000	\$3,500/ \$7,000	\$2,000/ \$4,000		\$4,200/ \$8,400▲
Prescription drug deductible	None			\$125/ \$312	\$250/ \$750	\$250†/ \$750†	\$100†/ \$300†	None	Combined with medical deductible
Prescription drug out-of-pocket limit	Combined with medical limit			Combined with medical limit		\$2,000/\$4,000			Combined with medical limit

**Emergency services**

Ambulance	10%			25%	20%	20%			
Emergency room	\$100 + 10%			\$150 + 25%‡	\$150 + 20%‡	\$75 + 20%	\$75 + 15%		15%

**Hearing services**

Hearing aids (per ear)	Any amount over \$3,000 every 36 months*		Any amount over \$3,000 every 36 months*		Any amount over \$3,000 every 3 years‡				
Routine annual hearing exam	Preferred Network: \$20 (\$40#) + 10% In Network: \$40 (\$80#) + 30%	Preferred Network: \$10 (\$20#) + 10% In Network: \$20 (\$40#) + 30%	\$0*		\$0			15%	

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans								
	Kaiser Permanente NW			Kaiser Permanente WA				Premera	
	Plan 1	Plan 2	Plan 3	Core 1	Core 2	Core 3	SoundChoice	HMO	
<b>Hospital services</b>									
Inpatient	20%			20%				15%	20%
Outpatient	20%			20%				15%	20%
<b>Office visits</b>									
Behavioral health	\$30*	\$25*	\$20*	\$30 + 20%	\$25 + 20%	\$20 + 20%	\$20 + 15%	\$10*	
Preventive care*	\$0*			\$0*				\$0*	
Primary care	\$30*	\$25*	\$20*	\$30 + 20%	\$25 + 20%	\$20 + 20%	\$20 + 15%	\$10*	
Specialist	\$40*	\$35*	\$30*	\$40 + 20%	\$35 + 20%	\$30 + 20%	\$30 + 15%	\$40*	
Urgent care	\$50*	\$45*	\$40*	\$30 (\$40#) + 20%	\$25 (\$35#) + 20%	\$20 (\$30#) + 20%	\$20 (\$30#) + 15%	\$25*	
Telemedicine/ virtual care	\$0*			\$10 (\$0* virtual care)				\$5* to \$40*‡	

What you pay ↘	Preferred Provider Organization (PPO) Plans								
	Kaiser Permanente WA Options			Premera		Uniform Medical Plan			
	Summit PPO 1	Summit PPO 2	Summit PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible
<b>Hospital services</b>									
Inpatient	Preferred Network:10%			25%	20%	\$200/day up to \$600‡			15%
Outpatient	In Network:30%					20%	15%		
<b>Office visits</b>									
Behavioral health	Preferred Network:\$20 + 10% In Network: \$40 + 30%	Preferred Network:\$10 + 10% In Network: \$20 + 30%		\$25*		20%	15%		
Preventive care*	\$0*			\$0*		\$0			
Primary care	Preferred Network:\$20 + 10% In Network: \$40 + 30%	Preferred Network:\$10 + 10% In Network: \$20 + 30%		\$25*				\$0	
Specialist	Preferred Network:\$40 + 10% In Network: \$80 + 30%	Preferred Network:\$20 + 10% In Network: \$40 + 30%		\$50		20%	15%		15%
Urgent care	Preferred Network:\$20 (\$40#) + 10% In Network: \$40 (\$80#) + 30%	Preferred Network:\$10 (\$20#) + 10% In Network: \$20 (40#) + 30%		25%	20%			15%	
Telemedicine/ telehealth/ virtual care	\$10* (\$0* virtual care)			\$5* to \$50*‡		Varies‡			

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans							
	Kaiser Permanente NW			Kaiser Permanente WA				Premera
	Plan 1	Plan 2	Plan 3	Core 1	Core 2	Core 3	SoundChoice	HMO

**Therapies** (price/visits per year)

Acupuncture	\$40*/20	\$35*/20	\$30*/20	\$30 + 20%/24	\$25 + 20%/24	\$20 + 20%/24	\$20 + 15%/24	
Chiropractic (spinal manipulations)	\$40*/no limit	\$35*/no limit	\$30*/no limit	\$30 (\$40#) + 20%/24	\$25 (\$35#) + 20%/24	\$20 (\$30#) + 20%/24	\$20 (\$30#) + 15%/24	\$10*/24
Massage therapy		\$25*/20		\$40#+ 20%/24	\$35#+ 20%/24	\$30# + 20%/24	\$30# + 15%/24	
Physical, occupational, speech, and neuro-developmental therapy (NDT)	\$40*/60	\$35*/60	\$30*/60	\$40#+ 20%/60 (no limit NDT)	\$35#+ 20%/60 (no limit NDT)	\$30# + 20%/60 (no limit NDT)	\$30# + 15%/60 (no limit NDT)	\$40*/45 (no limit NDT)‡

What you pay ↘	Preferred Provider Organization (PPO) Plans								
	Kaiser Permanente WA Options			Premera		Uniform Medical Plan			
	Summit PPO 1	Summit PPO 2	Summit PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible

**Therapies** (price/visits per year)

Acupuncture	Preferred Network: \$20 + 10%/24‡ In Network: \$40 + 30%	Preferred Network: \$10 + 10%/24‡ In Network: \$20 + 30%									
	Preferred Network: \$20 (\$40#) + 10%/24‡ In Network: \$40 (\$80#) + 30%	Preferred Network: \$10 (\$20#) + 10%/24‡ In Network: \$20 (\$40#) + 30%								\$25*/24	\$15/24
	Preferred Network: \$40 + 10%/24‡ In Network: \$80 + 30%	Preferred Network: \$20 + 10%/24‡ In Network: \$40 + 30%									
Chiropractic (spinal manipulations)											
Massage therapy											
Physical, occupational, speech, and neuro-developmental therapy (NDT)	Preferred Network: \$40# + 10%/60 (no limit NDT) In Network: \$80 + 30%	Preferred Network: \$20# + 10%/60 (no limit NDT) In Network: \$40 + 30%	\$50/45‡ (no limit NDT)	20%/80	15%/80	15%/60	15%/80				

# Behavioral health benefits

When accessing behavioral health services such as substance use disorder treatment, mental health counseling, etc. use the charts below to find out what you pay for behavioral health services. Most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.

What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans							
	Kaiser Permanente NW			Kaiser Permanente WA				Premera
	Plan 1	Plan 2	Plan 3	Core 1	Core 2	Core 3	SoundChoice	HMO
<b>Inpatient hospital treatment</b>								
Hospital – Mental health	20%	20%	20%	20%	20%	20%	15%	20%
Hospital – Substance use	20%	20%	20%	20%	20%	20%	15%	20%
Residential treatment facility	20%	20%	20%	20%	20%	20%	15%	20%
<b>Outpatient treatment</b>								
Hospital – Mental health	Not covered‡	Not covered‡	Not covered‡	20%	20%	20%	15%	20%
Hospital – substance use	\$30*/day	\$25*/day	\$20*/day	20%	20%	20%	15%	20%
Partial hospitalization (or day treatment program)	\$30* /day	\$25*/day	\$20*/day	20%	20%	20%	15%	20%
Intensive outpatient	\$30*/day	\$25*/day	\$20*/day	20%	20%	20%	15%	Professional services \$10 Facility 20%
Withdrawal management/detoxification	\$30*/day	\$25*/day	\$20*/day	20%	20%	20%	15%	20%

What you pay ↘	Preferred Provider Organization (PPO) Plans								
	Kaiser Permanente WA Options			Premera		Uniform Medical Plan			
	Summit PPO 1	Summit PPO 2	Summit PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible

**Inpatient hospital treatment**

Hospital – Mental health	Preferred Network:10% In Network:30%			25%	20%	Facility \$200/day up to \$600‡ Professional services 0%			15%
Hospital – Substance use				25%	20%				
Residential treatment facility				25%	20%				

**Outpatient treatment**

Hospital – Mental health	Preferred Network:10% In Network:30%			25%	15%	20%	15%	15%	
Hospital – Substance Use				25%					
Partial hospitalization (or day treatment program)				25%					
Withdrawal management/detoxification	Preferred Network: \$20 + 10% In Network: \$40+30%	Preferred Network: \$10+10% In Network: \$20+30%		25%					
Intensive outpatient – mental health	Preferred Network:10% In Network:30%			Professional services \$25 Facility 25%		15%	20%	15%	15%
Intensive outpatient – substance use	Preferred Network: \$20 + 10% In Network: \$40 + 30%	Preferred Network: \$10 + 10% In Network: \$20 + 30%							



What you pay ↘	Managed Care and Health Maintenance Organization (HMO) Plans							
	Kaiser Permanente NW			Kaiser Permanente WA				Premera
	Plan 1	Plan 2	Plan 3	Core 1	Core 2	Core 3	SoundChoice	HMO

**Office visit for accessing outpatient mental health and substance use services**

Mental health	\$30*	\$25*	\$20*	\$30 + 20%	\$25 + 20%		\$20 + 15%	\$10
Substance use	\$30*	\$25*	\$20*	\$30 + 20%			\$20 + 15%	\$10*
Primary/ Specialist	\$40*	\$35*	\$30*	\$30 + 20%			\$20 + 15%	\$40*
Urgent care – mental health & substance use disorder crisis services	\$50*	\$45*	\$40*	\$30 (\$40*)+ 20%	\$25 (\$35)+ 20%	\$20 (\$30#) + 20%	\$20 (\$30#) + 15%	20%
Telemedicine/ telehealth/ virtual care	\$0*	\$0*	\$0*	\$10 (\$0 virtual care)	\$10* (\$0 virtual care)	\$10* (\$0 virtual care)	\$10* (\$0 virtual care)	Telemedicine \$10* (\$40#) Virtual care \$10*

**Therapies (price/visits per year)**

Occupational and NDT	\$40*/60 (no limit for behavioral health diagnosis)	\$35*/60 (no limit for behavioral health diagnosis)	\$30*/60 (no limit for behavioral health diagnosis)	\$40# + 20%/60 (no limit for behavioral health diagnosis)	\$35# + 20%/60 (no limit for behavioral health diagnosis)	\$30# + 20%/60 (no limit for behavioral health diagnosis)	\$30# + 15%/60 (no limit for behavioral health diagnosis)	Professional services \$40/45 Facility 20%/45
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What you pay ↘	Preferred Provider Organization (PPO) Plans								
	Kaiser Permanente WA Options			Premera		Uniform Medical Plan			
	Summit PPO 1	Summit PPO 2	Summit PPO 3	High PPO	Standard PPO	Achieve 1	Achieve 2	UMP Plus	High Deductible

**Office visits for accessing outpatient mental health and substance use services**

Mental health				\$25*					
Substance use	Preferred Network: \$20 + 10% In Network: \$40 + 30%	Preferred Network: \$10 + 10% In Network: \$20 + 30%		\$25*					
Primary/ Specialist				\$50*					
Urgent care – mental health & substance use disorder crisis services	Preferred Network: \$20 (\$40#) + 10% In Network: \$40 (\$80#) + 30%	Preferred Network: \$10 (\$20#) + 10% In Network: \$20 (\$40#) + 30%		25%	15%	20%	15%	15%	15%
Telemedicine/ telehealth/ virtual care	\$10* (\$0 virtual care)			Telemedicine \$25*/(\$50#) Virtual care \$5* to \$25*					

**Therapies (price/visits per year)**

Occupational and NDT	Preferred Network: \$40 + 10% In Network: \$80 + 30%	Preferred Network: \$20 + 10% In Network: \$40 + 30%		Professional services \$45 Facility 25%/45 (no limit NDT)	20%/no limit		15%/no limit		
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## Prescription drug benefits

Amounts in the following tables show what you pay for prescription drugs. Under the prescription drug benefit, most copays and coinsurance do not apply until after you have paid your annual deductible unless noted that the deductible is waived.

**Note:** All plans cover legally required preventive prescription drugs at 100 percent of allowed amount with no deductible.

**Deductible is waived for covered insulins and you pay no more than \$35 per 30-day supply.**

Drug tiers	Kaiser Permanente NW					
	Retail (30-day supply)*			Mail-order (90-day supply)*		
	Plan 1	Plan 2	Plan 3	Plan 1	Plan 2	Plan 3
Generic	\$20	\$15	\$10	\$40	\$30	\$20
Preferred brand-name	\$40	\$30	\$20	\$80	\$60	\$40
Non-preferred brand-name	50% up to \$100			50% up to \$200		
Specialty	50% up to \$150			50% up to \$150/30 day supply		

Drug tiers	Kaiser Permanente WA							
	Retail (30-day supply)				Mail-order (90-day supply)			
	Core 1	Core 2	Core 3	SoundChoice	Core 1	Core 2	Core 3	SoundChoice
Preferred generic	\$5*	\$10*			\$10*	\$20*		
Preferred brand-name	\$25*				\$50*			
Non-preferred generic and brand-name	\$50*				\$100*			
Specialty	50% up to \$150*				50% up to \$150* (per 30-day supply)			

Drug tiers	Premera Blue Cross					
	Retail (30-day supply)			Mail-order (90-day supply)		
	HMO	High PPO	Standard PPO	HMO	High PPO	Standard PPO
Preferred generic	\$9*	\$9*		\$18*	\$18*	
Preferred brand-name	\$40*	\$40	30%	\$80*	\$80	30%
Non-preferred generic and brand-name	50%*	50%		50%*	50%	
Specialty (30-day supply only)	Not covered	Not covered		\$75‡*	\$75‡	40%‡

Drug tiers	Kaiser Permanente WA Options					
	Retail (30-day supply)			Mail-order (90-day supply)		
	Summit PPO 1	Summit PPO 2	Summit PPO 3	Summit PPO 1	Summit PPO 2	Summit PPO 3
Preferred generic	Preferred Network:\$10* In Network:\$20*	Preferred Network:\$5* In Network:\$15*		\$20*	\$10*	
Preferred brand-name	Preferred Network:\$20* In Network:\$40*	Preferred Network:\$30* In Network:\$60*		\$40*	\$60*	
Non-preferred generic and brand-name	Preferred Network:\$30* In Network:\$60*	Preferred Network:\$65* In Network:\$95*		\$60*	\$130*	
Specialty	\$150*			\$150* (per 30-day supply)		
Non-preferred specialty	30%			30%* (per 30-day supply)		

Drug tiers	Uniform Medical Plan							
	Retail and mail-order (30-day supply)				Retail and mail-order (90-day supply)			
	Achieve 1	Achieve 2	UMP Plus	High Deductible	Achieve 1	Achieve 2	UMP Plus	High Deductible
Value	5% up to \$10			15%; 5% up to \$10 ‡	5% up to \$30			15%; 5% up to \$30
Tier 1 (Primarily low-cost generic)	10% up to \$25			15%; 10% up to \$25 ‡	10% up to \$75			15%; 10% up to \$75
Tier 2 (Preferred brand-name, high-cost generic, and specialty drugs)	30% up to \$75; 30% up to \$35 ‡			15%; 30% up to \$35 ‡	30% up to \$225 30% up to \$105 ‡			15%; 30% up to \$105 ‡