Health Benefits Open Enrollment
Evaluate Coverage

Open Enrollment Starts: October 28, 2024 (8am) Ends: November 15, 2024 (5pm)

Evaluate Coverage: Use this chart to evaluate which plan may be the best fit for you.

In Network Coverage	Kaiser HMO	Premera Choice PPO	Premera Core PPO*
Employee Payroll Contribution Rates for 2025 The monthly amount you pay out of your paycheck when you enroll. *Non-Represented* Employee Rates Employee only Employee/Spouse Employee/Child(ren) Employee/Family	 $0.00 $83.85 $60.98 $167.70	 $0.00 $85.16 $61.94 $170.32	 $70.61 $304.84 $212.49 $498.92
Copay A flat dollar amount you pay for a covered health service. Copay amounts for office visits. *Deductibles and coinsurance do not apply when services require a copay.*	$10	$30	$15
Deductible The amount you may need to pay up front each calendar year before the plan begins to pay for covered services. *Not all services are subject to a deductible, such as preventive care.*	$0	$750 Individual $1,500 Family	$0
Coinsurance The portion of the cost you pay after you meet your annual deductible. Coinsurance is a percentage of the allowable amount. The plan pays a percentage of the allowable amount, and you pay a percentage.	0%	10%	0%
Out-of-pocket Maximum The most you'll pay in a calendar year for covered medical and prescription drug expenses. Copays, deductibles and coinsurance payments count toward the out-of-pocket maximum. Any covered expenses above the out-of-pocket maximum will generally be covered by the plan at 100% for the rest of the calendar year.	$2,000 Individual $4,000 Family	$1,500 Individual $3,000 Family	$1,500 Individual $3,000 Family
Mandatory Generic Rules on Prescriptions If a brand name is dispensed when a generic equivalent is available, the cost will be the difference in cost between the brand name drug and the generic equivalent in addition to the brand name copay amount.	No	Yes	No
Prescription Drug Retail Pharmacy Costs (30-day supply) Generic (Tier 1) Preferred Brand (Tier 2) Non-preferred Brand (Tier 3)	 $10 $10 Not Covered	 $10 $25 $45	 $10 $20 50%
Prescription Drug Mail Order Pharmacy Costs (90-day supply) Generic (Tier 1) Preferred Brand (Tier 2) Non-preferred Brand (Tier 3)	 $30 $30 Not Covered	 $25 $62 $112	 $20 $40 50%

Visit Connect2MyBenefits (c2mb.ajg.com/cityofbellevue/) for all employee payroll contribution rates and more!

**If you are currently eligible for the Premera Core plan and select Kaiser HMO or Premera Choice in 2025, the Premera Core plan is still an option in 2026.*