

Schedule of Benefits

**Prepared Exclusively for
The City of Seattle**

2021 City Preventive Plan*

Local 77 Employees

Open Choice (PPO) Medical

**Please note: In the attached document the effective date is 2020; however, this document represents the benefits for 2021 and minimal changes made to plan documents in 2021.*

To view minor changes for 2021, see the amendment at the end of the “book”.

Open Choice (PPO Medical) - 2019 City Preventive Plan

Local 77 Employees Schedule of Benefits

Prepared exclusively for:

Employer:	The City of Seattle
Contract number:	ASC-100290
	Schedule of Benefits 6A
Plan effective date:	January 1, 2020
Plan issue date:	March 30, 2020

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
 - “In-network coverage”, we mean you get care from **network providers**.
 - “Out-of-network coverage”, we mean you can get care from **out-of-network providers**.
 - “Other health care coverage”, we mean you can get care from an **out-of-network provider** when you could not reasonably get the services and supplies needed from a **network provider**. This includes when you get care from **out-of-network providers** during your **stay** in a **network hospital**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles, copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums. They are combined maximums between **network providers** and **out-of-network providers** unless we state otherwise.
- At the end of this schedule you will find detailed explanations about your:
 - **Deductible**
 - **Maximum out-of-pocket limits**
 - Maximums

Important note:

All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums		
	In-network coverage*	Out-of-network coverage*	Other health care*
Deductible			
You have to meet your Calendar Year deductible before this plan pays for benefits.			
Individual	\$0 per Calendar Year	\$250 per Calendar Year	\$0 per Calendar Year
Family	\$0 per Calendar Year	\$750 per Calendar Year	\$0 per Calendar Year
Common Accident Deductible			
Common Accident Deductible	\$0	\$250	\$0

Maximum out-of-pocket limit			
Maximum out-of-pocket limit per Calendar Year.			
Individual	\$500 per Calendar Year	\$3,250 per Calendar Year	\$500 per Calendar Year
Family	\$1,000 per Calendar Year	\$6,750 per Calendar Year	\$1,000 per Calendar Year

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Preventive care and wellness			

Routine physical exams			
Performed at a physician's office	100% per visit No deductible applies.	Not Covered	100% per visit No deductible applies.
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	Not Applicable	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.
Covered persons age 22 and over but less than 65: Maximum visits per Calendar Year	1 visit	Not Applicable	1 visit
Covered persons age 65 and over: Maximum visits per Calendar Year	1 visit	Not Applicable	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Preventive care immunizations			
Performed in a facility or at a physician's office	100% per visit No deductible applies	Not Covered (100% per visit No deductible applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Not Applicable	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)			
Performed at a physician's , obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No deductible applies	70% (of the recognized charge) per visit	100% per visit No deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit

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Preventive screening and counseling services			
Office visits <ul style="list-style-type: none"> • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs • Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer 	100% per visit No deductible applies	Not Covered	100% per visit No deductible applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per Calendar Year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	Not Applicable	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Misuse of alcohol and/or drugs maximums:			
Maximum visits per Calendar Year	5 visits*	Not Applicable	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Use of tobacco products maximums:			
Maximum visits per Calendar Year	8 visits*	Not Applicable	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.			
Sexually transmitted infection counseling maximums:			
Maximum visits per Calendar Year	2 visits*	Not Applicable	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.			
Genetic risk counseling for breast and ovarian cancer maximums:			
Genetic risk counseling for breast and ovarian	Not subject to any age or frequency limitations	Not Applicable	Not subject to any age or frequency limitations

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cancer			
Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Routine cancer screenings	100% per visit No deductible applies.	Not Covered	100% per visit No deductible applies.
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.	Not Applicable	Subject to any age, family history, and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna's secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*	Not Applicable	1 screening every 12 months*
*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.			
Prenatal care Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
Preventive care services only	100% per visit No deductible applies	70% (of the recognized charge) per visit	100% per visit No deductible applies
Important note: You should review the <i>Maternity and related newborn care</i> sections. They will give you more information on coverage levels for maternity care under this plan.			

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Comprehensive lactation support and counseling services			
Lactation counseling services – facility or office visits	100% per visit No deductible applies	70% (of the recognized charge) per visit	100% per visit No deductible applies
Lactation counseling services maximum visits per 12 months either in a group or individual setting	6 visits*	6 visits*	6 visits*
*Important note: Any visits that exceed the lactation counseling services maximum are covered under Physician services office visits.			
Breast feeding durable medical equipment			
Breast pump supplies and accessories	100% per item No deductible applies	70% (of the recognized charge) per item	100% per item No deductible applies
Important note: See the <i>Breast feeding durable medical equipment</i> section of the booklet for limitations on breast pump and supplies.			
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% per visit No deductible applies	70% (of the recognized charge) per visit	100% per visit No deductible applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*	2 visits*	2 visits*
*Important note: Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.			
Devices			
Female contraceptive device provided, administered, or removed, by a physician during an office visit	100% per item No deductible applies	70% (of the recognized charge) per item	100% per item No deductible applies
Female voluntary sterilization			
Inpatient	100% per admission No deductible applies	70% (of the recognized charge) per admission	100% per admission No deductible applies

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Outpatient	100% per visit No deductible applies	70% (of the recognized charge) per visit	100% per visit No deductible applies
Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Physicians and other health professionals			
Physicians and specialists office visits (non-surgical)			
Physician services			
Office hours visits (non-surgical) non preventive care	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Allergy injections			
Performed at a physician's or specialist office when you do not see the physician	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Immunizations that are not considered preventive care			
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialist			
Specialist office visits			
Office hours visits (non-surgical)	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Physician surgical services			
Physicians and specialists office visits			
Performed at a physician's office	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Performed at a specialist's office	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit

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	No deductible applies		No deductible applies
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit <i>(includes coverage for immunizations)</i>	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging onto your secure member website at www.aetna.com or calling the number on your ID card.

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Hospital and other facility care			
Hospital care			
Inpatient hospital	100% (of the negotiated charge) per admission No deductible applies	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission No deductible applies
Alternatives to hospital stays			
Outpatient surgery and physician surgical services			
	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Home health care			
Outpatient	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Maximum visits per Calendar Year	130 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge	130 Limited to: 3 intermittent visits per day provided by a participating home health care agency ; 1 visit equals a period of 4 hours or less. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care The intermittent requirement may be waived to allow coverage for up to 12 hours with a daily maximum of 3 visits. Services must be provided within 10 days of discharge

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Hospice care			
Inpatient facility	100% (of the negotiated charge) per admission No deductible applies	Not Covered	100% (of the recognized charge) per admission No deductible applies
Hospice care			
Outpatient	100% (of the negotiated charge) per visit No deductible applies	Not Covered	100% (of the recognized charge) per visit No deductible applies
	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day	Not Applicable	Part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours a day Part-time or intermittent home health aide services to care for you up to 8 hours a day
Maximum Benefit (inpatient and outpatient combined)	6 months, 6 additional months if authorized	Not Applicable	6 months, 6 additional months if authorized
Respite Care Maximum	10 days in a 6 consecutive month period	Not Applicable	10 days in a 6 consecutive month period
Outpatient private duty nursing			
Outpatient private duty nursing	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Skilled nursing facility			
Inpatient facility	100% (of the negotiated charge) per admission No deductible applies	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission No deductible applies
Maximum days per Calendar Year	120 days	120 days	120 days

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Emergency services and urgent care			
Emergency services			
Hospital emergency room	\$50 then the plan pays 100% (of the balance of the negotiated charge) per visit No deductible applies	Paid the same as in-network coverage.	Paid the same as in-network coverage.
Non-emergency care in a hospital emergency room	\$50 then the plan pays 100% (of the balance of the negotiated charge) per visit No deductible applies	\$50 then the plan pays 70% (of the balance of the recognized charge) per visit No deductible applies	\$50 then the plan pays 100% (of the balance of the recognized charge) per visit No deductible applies
<p>Important Note:</p> <ul style="list-style-type: none"> ▪ As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (deductible, copayment and payment percentage), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the member's ID number is on the bill. ▪ A separate hospital emergency room copayment/payment percentage will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/payment percentage will be waived and your inpatient copayment/payment percentage will apply. 			
Urgent care			
Urgent medical care (at a non- hospital free standing facility)	\$35 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	\$35 then the plan pays 100% (of the balance of the recognized charge) per visit thereafter No deductible applies
A separate urgent care deductible or copayment/payment percentage will apply for each visit to an urgent care provider .			

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Specific conditions			
Autism spectrum disorder			
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other illness under this plan			
Birth center			
Inpatient	100% (of the negotiated charge) per admission No deductible applies	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission No deductible applies
Family planning services - other			
Voluntary sterilization for males			
Outpatient	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Abortion			
Outpatient	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Maternity and related newborn care			
Inpatient	100% (of the negotiated charge) per admission No deductible applies	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission No deductible applies
Delivery services and postpartum care services			
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit

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	No deductible applies		No deductible applies
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Mental health treatment - inpatient			
Inpatient mental health treatment	100% (of the negotiated charge) per admission	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission
Inpatient residential treatment facility	No deductible applies		No deductible applies
Coverage is provided under the same terms, conditions as any other illness .			
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a physician or behavioral health provider includes telemedicine consultation	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Coverage is provided under the same terms, conditions as any other illness .			
Outpatient mental health treatment office visits to a physician or behavioral health provider includes telemedicine cognitive behavior therapy consultation	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Other outpatient mental health treatment (includes skilled behavioral health services in the home)	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Partial hospitalization treatment Intensive outpatient program The cost share doesn't apply to in-network peer counseling support services			
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Substance related disorders treatment - inpatient

Inpatient substance abuse detoxification during a hospital confinement Inpatient substance abuse rehabilitation during a hospital confinement Inpatient residential treatment facility during a hospital confinement Coverage is provided under the same terms, conditions as any other illness .	100% (of the negotiated charge) per admission No deductible applies	70% (of the recognized charge) per admission	100% (of the recognized charge) per admission No deductible applies
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Substance related disorders treatment - outpatient: detoxification and rehabilitation

Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultation) Coverage is provided under the same terms, conditions as any other illness .	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
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Outpatient substance abuse office visits to a physician or behavioral health provider includes	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
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<p>telemedicine cognitive behavioral therapy consultations</p> <p>Coverage is provided under the same terms, conditions as any other illness.</p>	No deductible applies		
<p>Other outpatient substance abuse services</p> <p>Partial hospitalization treatment</p> <p>Intensive outpatient program</p> <p>The cost share doesn't apply to in-network peer counseling support services.</p>	<p>100% (of the negotiated charge) per visit</p> <p>No deductible applies</p>	70% (of the recognized charge) per visit	<p>100% (of the recognized charge) per visit</p> <p>No deductible applies</p>

Oral and maxillofacial treatment (mouth, jaws and teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	<p>100% (of the negotiated charge) per visit</p> <p>No deductible applies</p>	<p>100% (of the recognized charge) per visit</p> <p>No deductible applies</p>	<p>100% (of the recognized charge) per visit</p> <p>No deductible applies</p>
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
All other Oral and maxillofacial treatment (mouth, jaws and teeth)	<p>100% (of the negotiated charge) per visit</p> <p>No deductible applies</p>	70% (of the recognized charge) per visit	<p>100% (of the recognized charge) per visit</p> <p>No deductible applies</p>
Accidental injury treatment Maximum Benefit	\$600 per occurrence	\$600 per occurrence	\$600 per occurrence

Reconstructive breast surgery			
Reconstructive breast surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

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Reconstructive surgery and supplies			
Reconstructive surgery	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	Network Institute of Excellence (IOE) facility	Network Non-IOE facility	Out-of-network coverage*	Other health care
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Transplant services facility and non-facility

Inpatient hospital transplant services	100% (of the negotiated charge) per transplant No deductible applies	70% (of the negotiated charge) per transplant	70% (of the recognized charge) per transplant	70% (of the recognized charge) per transplant
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
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Treatment of infertility

Basic infertility

Basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Infertility Drugs (prescribed by a Network Physician)	80% No Calendar Year deductible applies.	Not Covered	Not Covered
Infertility Drugs Maximum Benefit per Calendar Year	\$2,000	Not Applicable	Not Applicable

Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
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Specific therapies and tests

Outpatient diagnostic testing

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Diagnostic complex imaging services			
	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies
Diagnostic lab work			
	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies.
Diagnostic radiological services			
	100% (of the negotiated charge) per visit. No deductible applies.	70% (of the recognized charge) per visit.	100% (of the recognized charge) per visit. No deductible applies.
Chemotherapy			
Chemotherapy	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Outpatient infusion therapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy			
	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Short-term rehabilitation services			
Outpatient Physical, Massage, Occupational, Cardiac and Pulmonary Therapies			
	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter. No deductible applies	70% (of the recognized charge) per visit.	100% (of the recognized charge) per visit. No deductible applies

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Outpatient Speech Therapy			
	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter. No deductible applies	70% (of the recognized charge) per visit.	100% (of the recognized charge) per visit. No deductible applies

Outpatient Physical, Massage, Occupational, Cardiac and Pulmonary Therapies Maximum			
Maximum visits per Calendar Year	20	20	20

Outpatient Speech Therapy Maximum			
Maximum visits per Calendar Year	20	20	20

Habilitation therapy services			
	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter. No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Other services			

Acupuncture			
Acupuncture	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies.	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies.
All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity			

Ambulance service			
Ground, air or water ambulance	100% (of the negotiated charge) per trip No deductible applies.	100% (of the recognized charge) per trip No deductible applies.	100% (of the recognized charge) per trip No deductible applies.

Clinical trial therapies (experimental or investigational)			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Clinical trials (routine patient costs)			
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Durable medical equipment (DME)			
DME	100% (of the negotiated charge) per item No deductible applies	70% (of the recognized charge) per item	100% (of the recognized charge) per item No deductible applies

Hearing aids and exams			
Hearing aid exams	Covered according to the type of benefit and the	Covered according to the type of benefit and the	Covered according to the type of benefit and the

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

	place where the service is received	place where the service is received	place where the service is received
Hearing aids	100% (of the negotiated charge) per item No deductible applies.	100% (of the recognized charge) per item	100% (of the recognized charge) per item No deductible applies
Maximum per 36 month period	\$1,000 per ear	\$1,000 per ear	\$1,000 per ear
Non-preventive hearing exams			
For adults and children	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies.	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies.

Maximum	One exam in any 12 consecutive month period.
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Nutritional supplements			
Nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Prosthetic devices			
Prosthetic devices	100% (of the negotiated charge) per item No deductible applies.	70% (of the recognized charge) per item	100% (of the recognized charge) per item No deductible applies.
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500

Spinal manipulation			
Spinal manipulation	\$10 then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No deductible applies	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit No deductible applies

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Maximum visits per Calendar Year	20	20	20
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Eligible health services	In-network coverage*	Out-of-network coverage*
Outpatient prescription drugs		
Plan features	Deductible/Copayment/Payment Percentage/Maximums	
Deductible waiver		
The calendar year deductible is waived for all prescription drugs .		
Deductible and copayment/payment percentage waiver for risk reducing breast cancer prescription drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to risk reducing breast cancer prescription drugs when obtained at a network pharmacy . This means that such risk reducing breast cancer prescription drugs will be paid at 100%.		
Deductible and copayment/payment percentage waiver for tobacco cessation prescription and over-the-counter drugs		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to the first two 90-day treatment regimens for tobacco cessation prescription drugs and OTC drugs when obtained at a network pharmacy . This means that such prescription drugs and OTC drugs will be paid at 100%. Your Calendar Year deductible and any prescription copayment/payment percentage will apply after those two regimens have been exhausted.		
Deductible and copayment/payment percentage waiver for contraceptives		
The Calendar Year deductible and the per prescription copayment/payment percentage will not apply to female contraceptive methods when obtained at a network pharmacy . This means that the following will be paid at 100%:		
<ul style="list-style-type: none"> Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drugs for that method paid at 100%. 		
The Calendar Year deductible and the per prescription copayment/payment percentage continue to apply to prescription drugs that have a generic equivalent or generic alternative available within the same therapeutic drug class obtained at a network pharmacy unless you are granted a medical exception.		
Outpatient prescription drug maximum out-of-pocket limit		
Outpatient prescription drug maximum out-of-pocket limit per calendar year		
Individual	\$1,200 per Calendar Year	
Family	\$3,600 per Calendar Year	

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Generic prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply or 100 unit doses, whichever is greater filled at a retail pharmacy	<p>\$10 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
More than a 34 day supply but less than a 91 day supply or 300 unit doses, whichever is greater filled at a mail order pharmacy	<p>\$20 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 34 day supply or 100 unit doses, whichever is greater filled at a retail pharmacy	<p>\$20 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
More than a 34 day supply but less than a 91 day supply or 300 unit doses, whichever is greater filled at a mail order pharmacy	<p>\$40 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 30 day supply or 100 unit doses, whichever is greater filled at a retail pharmacy	<p>\$40 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered
More than a 34 day supply but less than a 91 day supply or 300 unit doses, whichever is greater filled at a mail order pharmacy	<p>\$80 copayment per supply</p> <p>Payment percentage is 100% (of the negotiated charge)</p> <p>No Calendar Year deductible applies</p>	Not covered

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Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a pharmacy	100% per prescription or refill	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy	100% per prescription or refill No deductible applies	Not covered
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy	\$0 per prescription or refill No deductible applies	Not covered
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and	

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	<p>frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure member website at www.aetna.com or calling the number on your ID card.</p>	

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General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**
- **Maximums**

that are listed in the first part of this schedule of benefits.

Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

Individual

This is the amount you owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family

This is the amount you and your covered dependents owe for out-of-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Common Accident Deductible

This limit applies when two or more family members are injured in the same accident. The common accident deductible limit places a limit on your **deductible** expenses when covered expenses are applied toward the separate Calendar Year **deductibles**. When this occurs, and all covered expenses related to the accident in that Calendar Year exceed the common accident deductible limit, your plan will then pay the excess amount based on the plan **payment percentage**. The added benefit will be reduced by any family deductible limit benefit amount paid for the same covered expenses.

Deductible carryover

Any amounts that you paid for **eligible health services** in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year

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deductibles.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services applied to the **out-of-network maximum out-of-pocket limit** will be applied to satisfy the in-network **maximum out-of-pocket limit** and **eligible health services** applied to the in-network **maximum out-of-pocket limit** will be applied to satisfy the out-of-network **maximum out-of-pocket limit**.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** or **recognized charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- Any out of pocket costs for outpatient **prescription drugs**
- As it applies to out-of-network coverage: Charges, expenses or costs in excess of the **recognized charge**

Maximum provisions

Eligible health services applied to the **out-of-network** maximum will not be applied to satisfy the network maximum and **eligible health services** applied to the network maximum will not be applied to satisfy the **out-of-network** maximum.

Calculations; determination of recognized charge; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

General coverage provisions

This section provides detailed explanations about the:

- Outpatient **prescription drug maximum out-of-pocket limits**

Outpatient prescription drug maximum out-of-pocket limits provisions

The outpatient **prescription drug maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments** for **eligible health services** during the Calendar Year. This plan has an individual and family outpatient **prescription drug maximum out-of-pocket limit**. As to the individual outpatient **prescription drug maximum out-of-pocket limit** each of you must meet your outpatient **prescription drug maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of the **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family outpatient **prescription drug maximum out-of-pocket limit**, this plan will pay 100% of such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

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To satisfy this family outpatient **prescription drug maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family outpatient **prescription drug maximum out-of-pocket limit** is a cumulative outpatient **prescription drug maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual outpatient **prescription drug maximum out-of-pocket limit** amount in a Calendar Year.

The outpatient **prescription drug maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the outpatient **prescription drug maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the outpatient **prescription drug maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the outpatient **prescription drug maximum out-of-pocket limit**. These include:

- All costs for non-covered services

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Amendment to Plan of Benefits

For Employees of: The City of Seattle
Administrative Services Agreement No.: 100290

Effective January 1, 2021, the following changes have been made to your Booklet and Schedule of Benefits.

- 1) The following section entitled “Habilitation therapy services” replaces the section under the same title in your Schedule of Benefits.

Habilitation therapy services			
	100% (of the negotiated charge) per visit	70% (of the recognized charge) per visit	100% (of the recognized charge) per visit
	No deductible applies		No deductible applies

- 2) The following section entitled “Immunizations” has been added to your Booklet.

Immunizations

Eligible health services include preventive immunizations as required by the ACA guidelines when administered at a **network pharmacy**. You should call the number on your ID card to find a participating **network pharmacy**. You should contact the **pharmacy** for availability, as not all **pharmacies** will stock all available vaccines.