Schedule of Benefits

Prepared Exclusively for
The City of Seattle

2021 City Preventive Plan – S.P.O.G*

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) - S.P.O.G. Preventive Plan
Schedule of Benefits

Prepared exclusively for:

Employer:	The City of Seattle
Contract number:	ASC-100290
	Schedule of Benefits 3A
Plan effective date:	January 1, 2020
Plan issue date:	June 5, 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	$3,000 per Calendar Year	$500 per Calendar Year
Family	$1,000 per Calendar Year	$6,000 per Calendar Year	$1,000 per Calendar Year

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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% (of the **negotiated charge**) per visit No **deductible** applies.	Not Covered	100% (of the **recognized charge**) 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's secure member website at www.aetna.com or calling the number on your ID card.	Not Covered	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's 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
Preventive care immunizations			
Performed in a facility or at a **physician's** office	100% (of the **negotiated charge**) per visit No **deductible** applies.	Not Covered	100% (of the **recognized charge**) per visit No **deductible** applies.
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on	Not Applicable	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on

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	Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna member website at www.aetna.com or calling the number on your ID card.		Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna 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** 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
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Maximum visits per Calendar Year	1 visit	1 visit	1 visit
Preventive screening and counseling services			
Office visits • 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% (of the **negotiated charge**) per visit No **deductible** applies	Not Covered	100% (of the **recognized charge**) per visit No **deductible** applies
Obesity and/or healthy diet counseling maximums:			
Maximum visits per Calendar Year	26 visits (however, of these, only 10 visits will be allowed under the	Not Applicable	26 visits (however, of these, only 10 visits will be allowed under the

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(This maximum applies only to covered persons age 22 and older.)	plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*		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 cancer	Not subject to any age or frequency limitations	Not Applicable	Not subject to any age or frequency limitations
Routine cancer screenings (applies whether performed at a physician's, specialist office or facility)			
Mammograms	100% (of the **negotiated charge**) per test No **deductible** applies	70% (of the **recognized charge**) per test	100% (of the **recognized charge**) per test No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States

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	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.	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.	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.
Prostate specific antigen (PSA) tests	100% (of the **negotiated charge**) per test No **deductible** applies	Not Covered	100% (of the **recognized charge**) per test No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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: • 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.

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Digital rectal exams	100% (of the **negotiated charge**) per exam No **deductible** applies	Not Covered	100% (of the **recognized charge**) per exam No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • 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 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: • 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 member website at www.aetna.com or calling the number on your ID card.
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**			
Performed in a facility or at a **physician's** office	$5 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
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Family planning services – female contraceptives			
Devices			

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Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	$5 then the plan pays 100% (of the balance of the **negotiated charge**) per item thereafter No **deductible** applies	70% (of the **recognized charge**) per item	100% (of the **recognized charge**) per item No **deductible** applies
Female voluntary sterilization			
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
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
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	$5 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)	$5 then the plan pays 100% (of the balance of the **negotiated charge**)	70% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit

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	per visit thereafter No **deductible** applies		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 No **deductible** applies	70% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit No **deductible** applies
Alternatives to physician office visits			
Walk-in clinic visits			
Walk-in clinic non-emergency visit *(includes coverage for immunizations)*	$5 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.

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	70% (of the **recognized charge**) per admission	100% (of the **recognized charge**) per admission No **deductible** applies
Maximum days per lifetime	Unlimited	Unlimited	Unlimited
Hospice 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
	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	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	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
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	120	120
Inpatient Rehabilitation Maximum Days per Calendar Year (Physical, Occupational, Speech, Cardiac and Pulmonary Therapy combined - in a hospital or skilled nursing facility)	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
Important Note: ▪ 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**.			

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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			
Birthing 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	100% (of the **negotiated**	70% (of the **recognized**	100% (of the **recognized**

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at a **physician's** office	**charge**) per visit No **deductible** applies	**charge**) per visit	**charge**) per visit 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 Inpatient **residential treatment facility** 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
Mental health treatment - outpatient			
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	$5 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 mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	$5 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

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Partial hospitalization treatment **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support services			
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
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**.	$5 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 **substance abuse** office visits to a	$5 then the plan pays 100% (of the balance of	70% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit

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physician or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	the **negotiated charge**) per visit thereafter No **deductible** applies		No **deductible** applies
Other outpatient **substance abuse** services **Partial hospitalization treatment** **Intensive outpatient program** The cost share doesn't apply to in-network peer counseling support 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
Eligible health services	**In-network coverage* Institute of Quality (IOQ) Facility**	**In-network coverage* Non-IOQ Facility**	**Out-of-network coverage***
Obesity surgery			
Inpatient **hospital** (includes surgical procedure and acute **hospital** services)	100% (of the **negotiated charge**) per admission No **deductible** applies	Not Covered	Not Covered
Outpatient obesity surgery			
	100% (of the **negotiated charge**) per visit No **deductible** applies	Not Covered	Not Covered

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Eligible health services	In-network coverage*	Out-of-network coverage*	Other health care
Oral and maxillofacial treatment (mouth, jaws and teeth)			
Orthodontic treatment directly related to an orthognathic surgical procedure	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
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)	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
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
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 (IOE facility)	Network (Non-IOE facility)	Out-of-network coverage*	Other health care
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.

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Eligible health services	**In-network coverage***	**Out-of-network coverage***	**Other health care**
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% (of the **negotiated** charge) per visit 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**
Specific therapies and tests			
Outpatient diagnostic testing			

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.

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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, Cardiac, Pulmonary and Occupational Therapies			
	$5 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 Speech Therapy			
	$5 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, Cardiac, Pulmonary and Occupational Therapies Maximum			
Maximum visits per Calendar Year	20	20	20
Outpatient Speech Therapy Maximum			
Maximum visits per Calendar Year	20	20	20

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Habilitation therapy services			
	$5 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

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

Acupuncture			
Acupuncture	$5 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	$5 (of the **recognized charge**) per visit No **deductible** applies.

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

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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 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
Hearing aids	100% (of the **negotiated charge**) per item No **deductible** applies.	100% (of the **recognized charge**) per item No **deductible** applies.	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
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	$5 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 visits per Calendar Year	20	20	20

*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*
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 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%.		
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%: • 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 31 day supply filled at a **retail pharmacy**	$5 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$10 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
Preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$10 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$20 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
Non-preferred brand-name prescription drugs (including specialty drugs)		
Per prescription copayment/payment percentage		
For each fill up to a 31 day supply filled at a **retail pharmacy**	$25 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered
More than a 31 day supply but less than a 91 day supply filled at a **mail order pharmacy**	$50 **copayment** per supply **Payment percentage** is 100% (of the **negotiated charge**) No Calendar Year **deductible** applies	Not covered

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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

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toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year **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 **payment percentage** 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 **payment percentage** 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 **payment percentage** 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

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benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

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

- All costs for non-covered services
- Amounts you pay toward a **deductible**
- **Copayment**
- 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.

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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.

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
- Amounts you pay toward a **deductible**
- **Copayment**

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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 No **deductible** applies	70% (of the **recognized charge**) per visit	100% (of the **recognized charge**) per visit No **deductible** applies

2) The following section entitled "Immunizations" has been added 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.

3) The following section entitled "Sexual dysfunction/enhancement" replaces the section under the same title in your Booklet.

Sexual dysfunction/enhancement
Eligible health services include **prescription drugs** for the treatment of sexual dysfunction/enhancement. For the most up-to-date information on dosing, call the toll-free number on your ID card.

4) The following section "Additional exclusions for specific types of care" sub-titled "Drugs or medications" replaces the section under the same title in your Booklet.

Drugs or medications
- Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- That includes the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
- That is therapeutically equivalent or therapeutically alternative to a covered **prescription drug** including **biosimilars** (unless a medical exception is approved)
- Not approved by the FDA or not proven safe and effective
- Provided under your medical plan while an inpatient of a healthcare facility
- That includes vitamins and minerals unless recommended by the United States Preventive Services Task

Force (USPSTF)

- For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
- That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications.
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies