2026 Medical Plan Comparison - Most City of Seattle Employees

The purpose of this document is to help you make decisions; it is not a contract. Details are provided in your medical plan booklet at https://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/most-employees-plans.

Kaiser	Permanente*	City of Seattle	Traditional Plan*	City of Seattle	e Preventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Deductible (per calen	dar year)	_	•		
No Deductible	\$200 per person	\$450 per person	\$1,000 per person	\$100 per person	\$450 per person
	\$600 per family	\$1,350 per family	\$3,000 per family	\$300 per family	\$1,350 per family
	Deductible applies as				
	noted except for	Deductible applies to m	ost services, except as	Deductible applies to m	nost services, except as
	prescriptions, preventive	noted. Deductible does	not apply for	noted. Deductible does	not apply for prescriptions
	visits, ambulance, and	prescriptions or when tl	ne Inpatient co-pay or	or when the Inpatient of	co-pay or emergency room
	durable medical	emergency room co-pay	/ applies.	co-pay applies.	
	equipment.				
Annual Out of Pocket	Maximum (OOP Max) inclu	des medical coinsurance	. The OOP Max includes	the deductible and exclu	des prescription drug
copays/coinsurance.					
Includes	medical copays	Excludes copays Excludes c		des copays	
\$2,000 per person	\$2,000 per person	\$1,450 per person	\$2,000 per person**	\$2,000 per person	\$3,000 per person*
\$4,000 per family	\$6,000 per family	\$4,350 per family	\$6,000 per family*	\$4,000 per family	\$6,000 per family*
Hospital Copay					
\$200 per admission	Deductible applies	\$200 copay	\$200 copay	\$200 copay	\$200 copay
		per admission	per admission	per admission	per admission
Hospital Pre-admission	n Authorization	_			
Except for maternity	or emergency admissions,	Except for maternity o	r emergency admissions,	Except for maternity or emergency admissions,	
must be authorize	d by Kaiser Permanente	your physician must co	ntact Aetna before your	your physician must	contact Aetna before your
		admission. The men	nber is responsible for	admission. The me	ember is responsible for
		obtaining precertifica	ition of out-of-network	obtaining precertificat	ion of out-of-network care.
		ca	ire.		

Kaiser P	ermanente*	City of Seattle T	raditional Plan*	City of Seattle	Preventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Choice of Providers					
All care and service Permanente Facilitie Members may sel	ces provided at Kaiser es or network providers If-refer to most Kaiser te specialists.	Aetna contracted providers. No primary care physician selection or referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	providers. No primary	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.
COVERED EXPENSES				•	
Abortion					
Paid at 100%	Paid at 100%	Paid at 100%. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.	Paid at 100%. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.	Paid at 100%. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.	Paid at 100%. Plan will pay up to \$10k travel and flodging allowance if service not available within 100 miles of your residence.
Acupuncture				•	
\$15 copay for up to 8 visits per medical diagnosis per calendar	\$15 copay for up to 8 visits per medical diagnosis per calendar	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 100% after \$15 copay.	Paid at 60% after deductible.
year. Additional visits when approved.	year. Additional visits when approved. Deductible applies.	Up to 12 visits per ca out-of-netwo	•	•	endar year in- and out-of- c combined
Alcohol/Drug Abuse Tr	eatment (inpatient)				
Paid at 100% after \$200 copay per admission	Paid at 100% after deductible		Paid at 60% after \$200 copay; no deductible.		Paid at 60% after \$200 copay; no deductible.
		situations, including centers and parti	residential treatment al hospitalization	1	sidential treatment centers hospitalization

Alcohol/Drug Abuse	Treatment (outpatient)				
	.5 Paid at 100% after \$15 co-	Paid at 80% after	Paid at 80% after	Paid at 100% after \$15	Paid at 100% after \$15
сорау	pay Deductible applies	deductible.	deductible.	copay.	copay.
		Additional focus on	review and coordination of	Additional focus on r	eview and coordination of
		care in comple	ex situations, including	care in complex situati	ons, including psychologica
		psychological testin	g, neurological testing, and	testing, neurologic	al testing, and intensive
		intensi	ve outpatient.	out	patient.
Contraceptives					
For contracept	tive drugs and devices,	IUDs and Dep	o Provera covered as	IUDs and Depo	Provera covered as
see Prescri	iption Drug benefit	medical benefits	No charge for preferred	medical benefits. No c	harge for preferred generic
		generic FDA-approv	ed women's contraceptives	FDA-approved wor	men's contraceptives in-
		in-network.		network.	
		See Prescri	otion Drug benefit.	See Prescrip	tion Drug benefit.
Durable Medical Equ	ipment				
Paid at 80%	Paid at 80%	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after
		deductible.	deductible.	deductible.	deductible.
		Breast pumps covere	ed	Breast pumps covered	
		as preventive care a	t	as preventive care at	
		100% no deductible		100% no deductible	
		through DME provider.		through DME provider.	
		Includes 1 electric l	preast pump per 12 months	Includes 1 electric breast pump per 12 months	
Emergency Medical (Care	•		•	
Urgent Care Clinic					
Paid at 100% after	\$15 copay	Paid at 80% after	Paid at 60% after	Paid at 100% after	Paid at 60% after
\$15 copay	Deductible applies	deductible.	deductible.	\$15 copay; no deductible.	deductible.

Kaiser P	ermanente*	City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Emergency Room (copa	ys waived if admitted)				
Kaiser Permanente	Kaiser Permanente facility:	Paid at 80% after	Paid at 80% after \$150	Paid at 90% after	Paid at 90% after
facility: \$100 copay	\$100 copay	\$150 copay; no	copay; no deductible.	\$150 copay; no	\$150 copay; no
Non-Kaiser Permanente	Non-Kaiser Permanente	deductible.	f non-emergency, paid	deductible.	deductible.
facility: \$150 copay	facility: \$150 copay	If non-emergency, paid	at 60% after copay.	If non-emergency, paid	If non-emergency, paid at
	Deductible applies	at 60% after copay.		at 60% after copay.	60% after copay.
Ambulance					
Paid at 80%.	Paid at 80%.	Paid at 80% when m	nedically necessary.	Paid at 90% when	medically necessary.
		Non-emergency transp	ortation only covered if	Non-emergency trans	portation only covered if
		approved in advance by	Aetna. Deductible does	approved in advance b	y Aetna. Deductible does
		not a			apply.
Gender Reassignment S	Services				
Covered as any other	Covered as any other	Covered as any other	Covered as any other	Covered as any other	Covered as any other
service;	service;	service;	service;	service;	service;
copays/coinsurance	copays/coinsurance	copays/coinsurance	copays/coinsurance	copays/coinsurance	copays/coinsurance
depending on type and	depend on type and	depend on type and	depend on type and	depend on type and	depend on type and
location of service	location of service	location of service	location of service	location of service	location of service
provided.	provided.	provided. Plan will pay	provided. Plan will pay	provided. Plan will pay	provided. Plan will pay up
		up to \$10k travel and	up to \$10k travel and	up to \$10k travel and	to \$10k travel and lodging
		lodging allowance if	lodging allowance if	lodging allowance if	allowance if service not
		service not available	service not available	service not available	available within 100 miles
		within 100 miles of your	within 100 miles of	within 100 miles of your	of your residence.
		residence.	your residence.	residence.	

Kaiser Pe	ermanente*	City of Seattle Tr	aditional Plan*	City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Fertility Services	· ·				
Procedures covered	Procedures covered	Procedures covered	Procedures covered	Procedures covered	Procedures covered
include artificial	include artificial	include artificial	include artificial	include artificial	include artificial
insemination, ovulation	insemination, ovulation	insemination, ovulation	insemination,	insemination, ovulation	insemination, ovulation
induction and Advanced	linduction, and Advanced	induction and Advanced	ovulation induction	induction and Advanced	induction and Advanced
Reproductive	Reproductive	Reproductive	and Advanced	Reproductive	Reproductive
Technologies.	Technologies.	Technologies.	Reproductive	Technologies.	Technologies.
Copays/coinsurance	Copays/coinsurance	Copays/coinsurance	Technologies.	Copays/coinsurance	Copays/coinsurance
depend on type and	depend on type and	depend on type and	Copays/coinsurance	depend on type and	depend on type and
location of service	location of service	location of service	depend on type and	location of service	location of service
provided. Regular cost	provided. Regular cost	provided. \$20,000	location of service	provided. \$20,000	provided. \$20,000 lifetime
shares apply to services	shares apply to services	lifetime maximum	provided. \$20,000	lifetime maximum	maximum benefit. Plan
associated with	associated with Artificial	benefit.	lifetime maximum	benefit. Plan will pay up	will pay up to \$10k travel
Artificial Insemination	Insemination and accrue	Plan will pay up to \$10k	benefit. Plan will pay	to \$10k travel and	and lodging allowance if
and accrue to medical	to medical out-of-pocket	travel and lodging	up to \$10k travel and	lodging allowance if	service not available
out-of-pocket max. All	max. All other fertility	allowance if service is no	tlodging allowance if	service is not available	within 100 miles of your
other fertility	treatments and pharmacy	available within 100	service is not available	within 100 miles of your	residence.
	accrue to \$20,000 lifetime		within 100 miles of	residence.	
pharmacy accrue to	maximum benefit.		your residence.		
\$20,000 lifetime					
maximum benefit.					
Hearing Aids (per ear, e	very 36 months)				
Paid at 100%	Paid at 100%	Paid 80% no deductible	Paid 80% no	Paid 90% no deductible	Paid 90% no deductible
			deductible		
		In-network coinsurar	nce applies whether		
		purchased in- or	out-of-network.		
		Deductible do	es not apply.		
		In-network coinsurar			
		purchased in- or	out-of-network.		
		Deductible do			

Kaiser P	Permanente*	City of Seattle T	raditional Plan*	City of Seattle Preventive Pl	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Home Health Care					
Paid at 100% when	Paid at 100%	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after
authorized. No visit	when authorized.	deductible.	deductible.	deductible.	deductible.
limit	No visit limit	Maximum benefit of 130 for in- and out-of-n	-		30 visits per calendar year -network combined
Hospital Inpatient		•			
Paid at 100% after	Paid at 100%	Facility: Paid at 80% after	Facility: Paid at 60%	Facility: Paid at 90%	Facility: Paid at 60% after
\$200 copay per	after deductible	\$200 copay; no	after \$200 copay; no	after \$200 copay; no	\$200 copay; no
admission		deductible.	deductible.	deductible.	deductible.
Hospital Outpatient					
Paid at 100% after	\$15 copay	Facility: Paid at 80% after	Facility: Paid at 60%	Facility: Paid at 90%	Facility: Paid at 60% after
\$15 copay	Deductible applies	deductible.	after deductible.	after deductible.	deductible.
Hospice					
Paid at 100%	Paid at 100%	Paid at 80% after	Paid at 60% after	Paid at 90% after	Not covered
when authorized	when authorized	deductible.	deductible.	deductible.	
Maternity Care (delive	ry & related hospital)				
Paid at 100% after	Deductible applies.	Facility: Paid at 80%	Facility: Paid at 60%	Facility: Paid at 90%	Facility: Paid at 60% after
\$200 copay		after	I I/	after	\$200 copay; copay waived
per admission		\$200 copay; copay		\$200 copay; copay	for newborn hosp.
		waived for newborn	•	waived for newborn	services. No deductible.
		hospital services. No	services. No deductible.	•	
		deductible.		deductible.	
Maternity Care (prena		1		T	
Paid at 100% after	\$15 copay	Other: Paid at 80% after		Other: Deductible and	Other: Paid at 60% after
\$15 copay	Deductible applies.	deductible.	after deductible.	coinsurance may apply.	deductible.
Routine care not	Routine care not subject				
subject to outpatient	to outpatient services	Pre-Natal (such as office	•	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `	Pre-Natal (such as office
services copay.	copay.	visits):100% no copay, no		visits):100% no copay,	visits): 60% after
		deductible.	deductible.	no deductible.	deductible.

Kaiser F	Permanente*	City of Seattle 1	Fraditional Plan*	City of Seattle	Preventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Mental Health Care (in	npatient)				
Paid at 100% after	Paid at 100% after	Paid at 80% after \$200	Paid at 60% after \$200	Paid at 90% after \$200	Paid at 60% after \$200
\$200 copay	deductible	copay; no deductible.	copay; no deductible.	copay; no deductible.	copay; no deductible.
			tion of care in complex		tion of care in complex
			residential treatment		idential treatment centers
		centers and parti	al hospitalization.	and partial h	nospitalization.
Mental Health Care (o	utpatient)				
Paid at 100% after	\$15 copay per session.	Paid at 80% after	Paid at 80% after	Paid at 100%	Paid at 100%
\$15 copay per session.	Deductible applies.	deductible.	deductible.		
				Ongoing consultation	
		Ongoing consultation		with a behavioral health	
		with a behavioral health		provider by web, phone,	
		provider by web, phone,		or mobile device through	
		or mobile device through	n	Teladoc also available.	
		Teladoc also available.			
		Additional focus on rev	iew and coordination of	Additional focus on rev	view and coordination of
			tuations, including		ns, including psychological
		_	neurological testing, and	-	I testing, and intensive
		intensive o	<u> </u>	<u> </u>	atient.
Physician Office Visit		intensive e	outputient.	σατρ	atient.
Paid at 100% after	Paid at 100% after	Paid at 80% after	Paid at 60% after	Paid at 100% after \$15	Paid at 60% after
\$15 copay.	\$15 copay.	deductible (waived for	deductible.	copay per visit (waived	deductible.
	Deductible applies	preventive care).		for preventive care).	
		Additional access to		Additional access to	
		medical consultation		medical consultation	
		with a physician by web,		with a physician by web,	
		phone, or mobile device		phone, or mobile device	
		for selected short-term		for selected short-term	
		services through Teladoo		services through Teladoo	
		also available.		also available.	

Kaiser P	ermanente*	City of Seattle Tra	aditional Plan*	City of Seattle P	reventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Prescription Drugs (ret	ail)				
For a 30-day supply:	For a 30-day supply:	Retail: 31-day supply; 90-	Not covered.	Retail: 31-day supply; 90-day	Not covered.
Generic: \$15 copay.	Generic: \$15 copay.	day supply for	9	supply for maintenance RX at	
Generic contraceptive	Generic contraceptive	maintenance RX at	Į.	participating retail	
drugs paid at	drugs paid at 100%.	participating retail	Į.	oharmacies same as mail	
100%.	Brand: \$30 copay	pharmacies same as mail	Į (order:	
Brand: \$30 copay	Brand contraceptive	order:			
Brand contraceptive	drugs and devices		ļ	Health Care Reform (HCR):	
drugs and devices	subject to copay	Health Care Reform (HCR):		certain preventive drugs	
subject to copay		certain preventive drugs		covered at 100%.	
		covered at 100%.			
				Generic: 30% coinsurance	
		Generic: 30% coinsurance	ļ	Brand: 40% coinsurance	
		Brand: 40% coinsurance	-	The per script minimum	
		The per script minimum		coinsurance is \$10, or actual	
		coinsurance is \$10, or	Į(cost of the drug if less.	
		actual cost of the drug if	I	Maximum is \$100 per drug.	
		less. Maximum is \$100 per			
		drug.			
Smoking cessation	Smoking cessation	Coinsurance applies to the p	rescription drug \$1,	200 out-of-pocket annual max	ximum per person,
prescription drugs not	prescription drugs not			reventive generic and brand d	
subject to	subject to	with a prescription including	contraceptives, sta	tins, and HIV. Prescription Allo	owance on all non-
pharmacy copay.	pharmacy copay.	sedating antihistamines (for	allergy symptoms) a	and Proton Pump Inhibitors (fo	or heartburn relief and
		ulcer treatment). City pays \$	20 per month, and p	olan participant pays remainin	ng; some over-the-
				for generic diabetic drugs and	
			• •	terol, and tobacco cessation d	
		20% for brand pharmacy.	_		-

Kaiser Pe	rmanente*	City of Seattle Trad	litional Plan*	City of Seattle Pro	eventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Prescription Drugs (ma	nil order)				
For a 90-day supply:	For a 90-day supply:	Mail Order: up to 90-day	Not Covered.	Mail Order: up to 90-day	Not Covered.
Generic: \$45 copay.	Generic: \$30 copay.	supply (32-90 day supply)		supply (32-90 day supply)	
Generic contraceptive	Generic contraceptive				
drugs paid at 100%.	drugs paid at 100%.	Health Care Reform		Health Care Reform (HCR):	
Brand: \$90 copay	Brand: \$60 copay	(HCR): certain preventive		certain preventive drugs	
Contraceptive drugs ar	nd devices are covered	drugs covered at 100%.		covered at 100%.	
subject to the pharmac	cy copay.	Generic: 30% coinsurance		Generic: 30% coinsurance	
		Brand: 40% coinsurance		Brand: 40% coinsurance	
		The per script minimum is		The per script minimum is	
		\$20; the maximum is		\$20; the maximum is	
		\$200 per drug.		\$200 per drug.	
Preventive and Wellne	ess Services				
Paid at 100% after	Paid at 100% after	Paid at 100% Services	Deductible and	Paid at 100% Services	Deductible and
\$15 copay	\$15 copay	recommended by the U.S.	coinsurance may	recommended by the U.S.	coinsurance may apply.
		Preventive Services Task	apply.	Preventive Services Task	
		Force (USPSTF). Includes		Force (USPSTF).	
		routine adult physical and		Includes routine adult	
		well-child exams,		physical and well-child exams	5,
		immunizations, digital		immunizations, digital rectal	
		rectal exams/prostate-		exams/prostate-specific	
		specific antigen test,		antigen test, lactation	
		lactation consultation,		consultation, and breast and	
		and breast and colorectal		colorectal cancer screenings.	
		cancer screenings.			

Kaiser Permanente*		City of Seattle Tra	City of Seattle Traditional Plan*		eventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Rehabilitation Service	s (inpatient)				
Paid at 100% after \$200 copay per admission	Paid at 100% after deductible. ays per calendar year	Paid at 80% after \$200 copay; no deductible.	Paid at 60% after \$200 copay; no ded.	Paid at 90% after \$200 copay; no deductible. Maximum of 120 days per	Paid at 60% after \$200 copay; no deductible.
	ther therapy benefits)			nursing and rehab service comb	es in- and out-of-network
Rehabilitation Service	<u> </u>				
Paid at 100% after \$15 copay \$15 copay Deductible applies. Maximum of 60 visits per calendar year (combined with other therapy benefits) Twenty-five visits per calendar year physical, massage and occupational therapy includes outpatient hospital services. Additional visits may be covered if deemed medically necessary.		deductible. r calendar year for occupational therapy hospital services. e covered if deemed	Paid at 100% after \$15 copay; no deductible. Twenty-five visits per cal massage and occupational t hospital services. Addition deemed medica	herapy includes outpatient al visits may be covered if	
Skilled Nursing Facility		L		I	
Paid at 100%. 60-day maximum per calendar year.	Paid at 100% after deductible. 60-day maximum per calendar year.	Paid at 80% after \$200 copay; no deductible. Maximum of 90 days po in- and out-of-nety	•	Paid at 90% after \$200 copay; no deductible. Maximum of 120 days pe services and skilled nursin comb	g in- and out-of-network
Smoking Cessation					
Paid at 100% for individual or group sessions Nicotine replacement Prescription Drug bene	or group sessions therapy included in	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic 20% brand. See Prescription Drugs.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered

Kaiser Permanente*		City of Seattle Tra	ditional Plan*	City of Seattle Preventive Plan*		
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network	
Spinal Manipulations (chiropractic)	•		•		
Paid at 100% after \$15 copay	\$15 copay. Deductible applies.	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 100% after \$15 copay; no deductible.	Paid at 60% after deductible.	
Self-referral to Kaiser Permanente designated providers. Must meet Kaiser Permanente protocol. Maximum of 10 visits per calendar year.		Maximum of 10 visits per calendar year for in-network and out-of-network combined.		Maximum of 20 visits per calendar year for in-network and out-of-network combined.		
Sterilization Procedure	es .					
Inpatient: Paid at 100% after \$200 copay	Inpatient: Paid at 100%	Inpatient: Paid at 80% after \$200 copay.	Inpatient: Paid at 60% after \$200 copay.	Inpatient: Paid at 90% after \$200 copay; no ded.	Inpatient: Paid at 60% after \$200 copay; no deductible.	
Outpatient: Paid at 100% after \$15 copay	Outpatient: \$15 copay Deductible applies	Outpatient: Paid at 80% after deductible. Tubal ligation: 100% no copay; no deductible.	Outpatient: Paid at 60% after deductible.	Outpatient: Paid at 90% after deductible. Tubal ligation: 100% no copay; no deductible.	Outpatient: Paid at 60% after deductible.	
Temporomandibular Jo	oint Services					
Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided. \$5,000 lifetime maxim services in- and out-of-	depend on type and location of service provided. um for non-surgical	Covered as any other service; copays/coinsurance depend on type and location of service provided. \$5,000 lifetime maximum f and out-of-nety	depend on type and location of service provided. or non-surgical services in-	

Kaiser Pe	rmanente*	City of Seattle Tra	aditional Plan*	City of Seattle P	reventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Tooth Injury/Oral Surg	ery (due to accident)	•	·		
Not covered	Not covered	Inpatient: Paid at 80% after \$200 copay	Inpatient: Paid at 60% after \$200 copay	Inpatient: Paid at 90% after \$200 copay	after \$200 copay
		Outpatient: Paid at 80% after deductible.	Outpatient: Paid at 60% after deductible.	Outpatient: Paid at 100% after \$15 copay for office visit. Other charges paid at 90%	Outpatient: Paid at 60%
Vision Exam/Hardward	 e			Те и по станува раза и се сус	
Exam: Paid at 100% after \$15 copay. One exam every 12 months. Hardware: Not covered.	Exam: Paid at 100% after \$15 copay. One exam every 12 months. Hardware is not covered.	Covered un	der VSP.	Covered u	nder VSP.
X-ray and Lab Tests Paid at 100%	Paid at 100% Deductible applies	Paid at 80% after deductible. Provider responsible for obtaining precertification of high-tech radiology		Paid at 90% after deductible Provider responsible for obtaining precertification of high-tech radiology	deductible.

^{*} a. Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.

Plan details are in your medical plan booklet at <u>seattle.gov/human-resources/benefits/employees-and-covered-family-members</u>. This document is not a contract.

b. Accolade advocacy services will be available to assist you and your covered family members find providers; dealing with billing, claim and appeals problems; understanding diagnoses and treatment options, and managing chronic diseases.