2024 Medical Plans Comparison – City of Seattle Fire Retirees Under Age 65

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/retirees/leoff-fire.

Kaiser Po	ermanente*	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 calenda	ar 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	lost 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 o	o-pay or emergency room
	durable medical	emergency room co-pay	y applies.	co-pay applies.	
	equipment.				
Annual Out of Pocket N	Maximum (OOP Max) inclue	des medical coinsurance	. The OOP Max includes	the deductible and exclue	des prescription drug
copays/coinsurance.					
Includes m	nedical copays	Excludes copays		Excludes 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	Authorization				
Except for maternity of	or emergency admissions,	Except for maternity o	r emergency admissions,	Except for maternity or emergency admissions,	
must be authorized	by Kaiser Permanente	your physician must co	ontact Aetna before your	your physician must o	contact Aetna before your
		admission. The men	nber is responsible for	admission. The me	mber is responsible for
		obtaining precertifica	ition of out-of-network	obtaining precertificati	on of out-of-network care.
		care.			

Kaiser Permanente*		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
Choice of Providers					
All care and services provided at Kaiser Permanente Facilities or network providers Members may self-refer to most Kaiser Permanente 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% after \$15 copay	\$15 copay Deductible applies	Paid at 80% after deductible. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.	within 100 miles of	up to \$10k travel and lodging allowance if service not available	Paid at 60% after deductible. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.
Acupuncture		,	1		
\$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits	\$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits	Paid at 80% after deductible. Up to 12 visits per ca	Paid at 60% after deductible. alendar year in- and	Paid at 100% after \$15 copay. Up to 20 visits per cal	Paid at 60% after deductible. endar year in- and out-of-
when approved.	when approved. Deductible applies.	out-of-netwo	rk combined		combined
Alcohol/Drug Abuse Tr	eatment (inpatient)				
Paid at 100% after \$200 copay per admission	Paid at 100% after deductible	Paid at 80% after \$200 copay; no deductible.	Paid at 60% after \$200 copay; no deductible.	Paid at 90% after \$200 copay; no deductible.	Paid at 60% after \$200 copay; no deductible.
		Review and coordination of care in complex situations, including residential treatment centers and partial hospitalization		situations, including res	ation of care in complex sidential treatment centers hospitalization

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
Alcohol/Drug Abuse Tr	eatment (outpatient)				
Paid at 100% after \$15 copay	Paid at 100% after \$15 co- pay Deductible applies	care in complex psychological testing,	Paid at 60% after deductible. view and coordination of situations, including neurological testing, and outpatient.	care in complex situation testing, neurologica	Paid at 60% after deducible. eview and coordination of ons, including psychological al testing, and intensive patient.
Contraceptives		interisive			
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. No charge for preferred generic FDA-approved women's contraceptives in-network.		IUDs and Depo Provera covered as medical benefits. No charge for preferred generic FDA-approved women's contraceptives in-network.	
		See Prescripti	on Drug benefit.	See Prescript	ion Drug benefit.
Durable Medical Equip	ment				
Paid at 80%	Paid at 80%	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 90% after deductible.	Paid at 60% after deductible.
		Breast pumps covered as preventive care at 100% no deductible through DME provider.		Breast pumps covered as preventive care at 100% no deductible through DME provider.	
		Includes 1 electric bre	east pump per 12 months	Includes 1 electric bre	east pump per 12 months
Emergency Medical Ca	re				
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 Permanente*		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	ays 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	by Aetna. Deductible does
		not a	oply.	not apply.	
Gender Reassignment	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	rmanente*	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
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	induction, 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. \$20,000	provided. \$20,000 lifetime	provided. \$20,000	location of service	provided. \$20,000	provided. \$20,000 lifetime
lifetime maximum	maximum benefit.	lifetime maximum	provided. \$20,000	lifetime maximum	maximum benefit. Plan
benefit.		benefit.	lifetime maximum	benefit. Plan will pay up	will pay up to \$10k travel
		Plan will pay up to \$10k	benefit. Plan will pay up	to \$10k travel and	and lodging allowance if
		travel and lodging	to \$10k travel and lodging	lodging allowance if	service not available
		allowance if service is no	tallowance if service is not	service is not available	within 100 miles of your
		available within 100	available within 100 miles of your residence.	within 100 miles of your	residence.
		miles of your residence.		residence.	
Hearing Aids (per ear, ev	very 36 months)				
Up to \$1,000 l	Jp to \$1,000	Paid 80% no deductible	Paid 80% no deductible	Paid 90% no deductible	Paid 90% no deductible
	I	up to \$1,500 per ear	up to \$1,500 per ear	up to \$1,500 per ear	up to \$1,500 per ear max.
	I	max.	max.	max.	
		In-network coinsurar	nce applies whether	In-network coinsurance	applies whether purchased
		purchased in- or c	out-of-network.	in- or out-	of-network.
		Deductible doe	es not apply.	Deductible o	loes not apply.
Home Health Care					
				Paid at 90% after	Paid at 60% after
authorized. No visit	when authorized.	deductible.	deductible.	deductible.	deductible.
limit M	No visit limit	Maximum benefit of 130	visits per calendar year	Maximum benefit of 13	30 visits per calendar year
		for in- and out-of-ne	etwork combined	for in- and out-of	-network combined

Kaiser	Permanente*	City of Seattle T	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	
Hospital Inpatient						
Paid at 100% after	Paid at 100%	Facility: Paid at 80% after	^r 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	^r 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	ery & 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	after \$200 copay;	after	\$200 copay; copay waived	
per admission		\$200 copay; copay	copay waived for	\$200 copay; copay	for newborn hosp.	
		waived for newborn	newborn hosp.	waived for newborn	services. No deductible.	
		hospital services. No	services. No deductible	hospital services. No		
		deductible.		deductible.		
Maternity Care (prena	ital and postpartum)					
Paid at 100% after	\$15 copay	Other: Paid at 80% after	Other: Paid at 60%	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.	сорау.	visits):100% no copay, no		visits):100% no copay,	visits): 60% after	
		deductible.	deductible.	no deductible.	deductible.	
Mental Health Care (in	1 1					
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.	
		Review and coordinat	ion of care in complex	Review and coordina	ation of care in complex	
		situations, including	residential treatment	situations, including res	idential treatment centers	
		centers and partia	al hospitalization.	and partial	hospitalization.	
Mental Health Care (c	outpatient)					

Kaiser	Permanente*	City of Seattle	City of Seattle Traditional Plan*		Preventive Plan*	
Standard Plan Deductible Plan		Aetna In-Network	Out-of-Network	Aetna In-Network Out-of-Network		
Paid at 100% after	\$15 copay per session.	Paid at 80% after	Paid at 80% after	Paid at 100% after	Paid at 60% after	
\$15 copay per session.	. Deductible applies.	deductible.	deductible.	\$15 copay; no	deductible.	
				deductible.		
		Ongoing consultation				
		with a behavioral health		Ongoing consultation		
		provider by web, phone		with a behavioral health		
		or mobile device throug	h	provider by web, phone,		
		Teladoc also available.		or mobile device through	ו	
				Teladoc also available.		
		Additional focus on review and coordination of		Additional focus on re-	view and coordination of	
		care in complex s	care in complex situations, including		care in complex situations, including psychological	
		psychological testing, neurological testing, and		testing, neurological testing, and intensive		
		intensive	outpatient.	outp	atient.	
Physician Office Visit						
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	1	phone, or mobile device		
		for selected short-term		for selected short-term		
		services through Telado	с	services through Teladoo	:	
		also available.		also available.		

Kaiser Pe	ermanente*	City of Seattle Trad	itional Plan*	City of Seattle Pr	eventive 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: Generic : \$15 copay.	For a 30-day supply: Generic : \$15 copay.	Retail: 31-day supply	Not covered.	Retail: 31-day supply	Not covered.	
Generic contraceptive drugs paid at 100%. Brand: \$30 copay Brand contraceptive drugs and devices subject to copay	Generic contraceptive drugs paid at 100%. Brand: \$30 copay Brand contraceptive drugs and devices subject to copay	Health Care Reform (HCR): certain preventive drugs covered at 100%. Generic: 30% coinsurance Brand: 40% coinsurance The per script minimum coinsurance is \$10, or actual cost of the drug if less. Maximum is \$100 per drug.		Health Care Reform (HCR): certain preventive drugs covered at 100%. Generic: 30% coinsurance Brand: 40% coinsurance The per script minimum coinsurance is \$10, or actual cost of the drug if less. Maximum is \$100 per drug.		
Smoking cessation prescription drugs not subject to pharmacy copay.	Smoking cessation prescription drugs not subject to pharmacy copay.	\$3,600 per family. Certain I with a prescription includin sedating antihistamines (fo ulcer treatment). City pays counter medications are al	Health Care Reform og contraceptives, st or allergy symptoms) \$20 per month, and so included. \$5 copa nma, anti-high chole	1,200 out-of-pocket annual m preventive generic and brand atins, and HIV. Prescription A and Proton Pump Inhibitors I plan participant pays remain ay for generic diabetic drugs a esterol, and tobacco cessation	l drugs covered at 100% llowance on all non- (for heartburn relief and ing; some over-the- nd supplies, \$15 copay for	

Kaiser P	ermanente*	City of Seattle Trac	ditional Plan*	City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Prescription Drugs (m	ail 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	supply (32-90 day supply)		supply (32-90 day supply)	
Generic contraceptive	copay.				
drugs paid at 100%.	Generic contraceptive	Health Care Reform (HCR)	:	Health Care Reform (HCR):	
Brand: \$90 copay	drugs paid at 100%.	certain preventive drugs		certain preventive drugs	
	Brand: \$60 copay	covered at 100%.		covered at 100%.	
Contraceptive drugs a	nd devices are covered	Generic: 30% coinsurance		Generic: 30% coinsurance	
subject to the pharma	су сорау.	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 Welln	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>U.S.</u>	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, and	l	consultation, and breast and	
		breast and colorectal		colorectal cancer screenings.	
		cancer screenings.			
Rehabilitation Service					
Paid at 100% after		rPaid at 80% after		Paid at 90% after	Paid at 60% after
\$200 copay per	deductible.	\$200 copay; no	\$200 copay; no ded.	\$200 copay; no deductible.	\$200 copay; no
admission		deductible.			deductible.
	ays per calendar year			Maximum of 120 days per o	-
(combined with ot	her therapy benefits)			nursing and rehab services	
				combin	ned

Kaiser Permanente*		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
Rehabilitation Service	s (outpatient)	•	·	-	·
Paid at 100% after \$15 copay \$15 copay Deductible applies. Maximum of 60 visits per calendar year (combined with other therapy benefits)		deductible. deductible. \$ Twenty-five visits per calendar year for physical, massage and occupational therapy		Paid at 100% after \$15 copay; no deductible. deductible. Twenty-five visits per calendar year for physical, massage and occupational therapy includes outpatient hospital services. Additional visits may covered if deemed medically necessary.	
Skilled Nursing Facility	1		· · · · · · · · · · · · · · · · · · ·		
Paid at 100%. 60-day maximum per calendar year. Smoking Cessation		Paid at 80% after \$200 copay; no deductible. Maximum of 90 days pe in- and out-of-nety	,	Paid at 90% after \$200 copay; no deductible. Maximum of 120 days pe services and skilled nursir comb	deductible. r calendar year for rehab ng in- and out-of-network
Paid at 100%	Paid at 100%	Lifetime maximum of	Not covered	Smoking cessation	Not covered
for individual or group sessions Nicotine replacement Prescription Drug bene	for individual or group sessions therapy included in	one 90-day supply of aids or drugs. Coinsurance 10% generic 20% brand. See Prescription Drugs.		prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	
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 for in-network and out-c		Maximum of 20 visit for in-network and out-	

Kaiser Pe	ermanente*	City of Seattle Tra	aditional Plan*	City of Seattle P	City of Seattle Preventive Plan*		
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network		
Sterilization Procedure	es						
Inpatient: Paid at 100% after \$200 copay	6 Inpatient: Paid at 100%	Inpatient: Paid at 80% after \$200 copay.	60% after \$200	Inpatient: Paid at 90% after \$200 copay; no ded.	Inpatient: Paid at 60% after \$200 copay; no deductible.		
Outpatient: Paid at	Outpatient: \$15 copay	Outpatient: Paid at 80%					
100% after \$15 copay	Deductible applies	after deductible.	Outpatient: Paid at 60% after	Outpatient: Paid at 90% after deductible.	Outpatient: Paid at 60% after deductible.		
		Tubal ligation: 100% no copay; no deductible.	deductible.	Tubal ligation: 100% no copay; no deductible.			
Temporomandibular J	oint Services						
Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance	copays/coinsurance	Covered as any other service; copays/coinsurance depend	• • •		
depend on type and location of service provided.	depend on type and location of service provided.	depend on type and location of service provided.	location of service provided.	on type and location of service provided.	depend on type and location of service provided.		
		\$5,000 lifetime maxim services in- and out-of-	•	\$5,000 lifetime maximum f and out-of-netv			
Tooth Injury/Oral Sur	gery (due to accident)						
Not covered	Not covered	Inpatient: Paid at 80% after \$200 copay	•	Inpatient: Paid at 90% after \$200 copay	Inpatient: Paid at 60% 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%		

Kaiser Per	manente*	City of Seattle Traditional Plan*		City of Seattle Pre	ventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of- Network	Aetna In-Network	Out-of-Network
Vision Exam/Hard	lware		·		
Exam: Paid at 100% after \$15 copay. One exam every 12 months. Hardware: Not covered.	Exam: Paid at 100% after a \$15 copay. One exam every 12 months. Hardware: Not covered.	Hardware: Two lense year; The lenses are betwe Single vision lens Bifocal vision lens Trifocal vision lens	ar year es per calendar een \$40 - \$130 \$40 per lens \$60 per lens \$80 per lens	calendar year ar 0 Hardware: Not covered. Discounts at:	
X-ray and Lab Tes Paid at 100%	Paid at 100%	Lenti vision lens \$ Frames; \$30 every Paid at 80% Provider responsible		eyemedvisioncare.com/member/public/o Paid at 90% Provider responsible for obtaining	Paid at 60%
	applies	for obtaining precertification of high-tech radiology		precertification of high-tech radiology	,

* a. Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.
b. Accolade advocacy services will be available to assist you and your covered family members in finding providers; deal with billing, claim

and appeals problems; understand diagnoses and treatment options, and manage chronic diseases.

Plan details are in your medical plan booklet at https://www.seattle.gov/human-resources/benefits/retirees/leoff-fire. This document is not a contract.