## **2024** 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 <a href="https://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/most-employees-plans">https://www.seattle.gov/human-resources/benefits/employees-and-covered-family-members/most-employees-plans</a>.

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
Deductible (per calenda	r 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	1			
	except for prescriptions,	Deductible applies to mo	st services, except as noted.	Deductible applies to mos	st services, except as noted.
	preventive visits,	Deductible does not appl	y for prescriptions or when	Deductible does not appl	y for prescriptions or when the
	ambulance, and durable	the Inpatient co-pay or e	mergency room co-pay	Inpatient co-pay or emer	gency room co-pay applies.
	medical equipment.	applies.			
Annual Out of Pocket M	aximum (OOP Max) includes i	medical coinsurance. The	OOP Max includes the deduc	tible and excludes prescrip	otion drug
copays/coinsurance.					
Includes	medical 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	or emergency admissions,	Except for maternity or	emergency admissions, your	Except for maternity or emergency admissions, your	
must be authorize	d by Kaiser Permanente	physician must contact A	etna before your admission.		
		The member is res	ponsible for obtaining	The member is responsible for obtaining	
		precertification of out-of-network care.		precertification of out-of-network 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					
Facilities or network p	ovided at Kaiser Permanente roviders Members may self- r Permanente specialists.	Aetna contracted providers No primary care physician selection or referrals required.		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.
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.	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.	Paid at 90% after deductible. Plan will pay up to \$10k travel and lodging allowance if service not available within 100 miles of your residence.	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		·			
\$15 copay for up to 8 visits per medical diagnosis per calendar	\$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional	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.	visits when approved. Deductible applies.	Up to 12 visits per ca out-of-netwo	•	Up to 20 visits per calendar year in- and out-of-network combined	
Alcohol/Drug Abuse Tre	atment (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		Review and coordination of care in complex situation including residential treatment centers and partial hospitalization	

Kaiser I	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
Alcohol/Drug Abuse Trea	atment (outpatient)				
Paid at 100% after \$15 copay	Paid at 100% after \$15 co- pay Deductible applies	in complex situations testing, neurologica	Paid at 60% after deductible. ew and coordination of care including psychological at testing, and intensive patient.	complex situations, incl	Paid at 60% after deducible.  w and coordination of care in uding psychological testing, and intensive outpatient.
Contraceptives		2.54			
•	ve drugs and devices, tion Drug benefit	medical benefits. No cl	Provera covered as harge for preferred generic contraceptives in-network.	IUDs and Depo Provera covered as medical benefits. No charge for preferred generic Fl approved women's contraceptives in-network.	
			ion Drug benefit.	See Prescription Drug benefit.	
Durable Medical Equipm	ent				
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.		
		Includes 1 electric bre	east pump per 12 months	Includes 1 electric bre	east pump per 12 months
Emergency Medical Care	1	•		•	, , ,
Urgent Care Clinic					
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.
Emergency Room (copay	s waived if admitted)				
Kaiser Permanente facility: \$100 copay Non-Kaiser Permanente facility: \$150 copay	Kaiser Permanente facility: \$100 copay Non-Kaiser Permanente facility: \$150 copay Deductible applies	Paid at 80% after \$150 copay; no deductible. If non-emergency, paid at 60% after copay.	copay; no deductible. If non-emergency, paid at	Paid at 90% after \$150 copay; no deductible. If non-emergency, paid at 60% after copay.	Paid at 90% after \$150 copay; no deductible. If non-emergency, paid at 60% after copay.

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
Ambulance					1
Paid at 80%.	Paid at 80%.	Paid at 80% when m			medically necessary.
		Non-emergency transpo	•		portation only covered if
		approved in advance by A			Aetna. Deductible does not
	•	appl	у.	ar	oply.
Gender Reassignment Se		1		1	
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; copays/coinsurance		•	service;	service; copays/coinsurance
copays/coinsurance	depend on type and location	• • •	• • •	copays/coinsurance	depend on type and location
depending on type and	of service provided.	depend on type and		depend on type and	of service provided. Plan will
location of service		location of service		location of service	pay up to \$10k travel and
provided.		provided. Plan will pay up			lodging allowance if service
		to \$10k travel and lodging	•	to \$10k travel and lodging	
		allowance if service not	0 0	allowance if service not	miles of your residence.
		available within 100 miles		available within 100 miles	
		of your residence.	within 100 miles of your	of your residence.	
			residence.		
Fertility Services					
Procedures covered	Procedures covered include	Procedures covered include	Procedures covered	Procedures covered	Procedures covered include
include artificial	artificial insemination,	artificial insemination,	include artificial	include artificial	artificial insemination,
insemination, ovulation	ovulation induction, and	ovulation induction and	insemination, ovulation	insemination, ovulation	ovulation induction and
induction and Advanced	Advanced Reproductive	Advanced Reproductive	induction and Advanced	induction and Advanced	Advanced Reproductive
Reproductive	Technologies.	Technologies.	Reproductive	Reproductive	Technologies.
Technologies.	Copays/coinsurance depend	Copays/coinsurance	Technologies.	Technologies.	Copays/coinsurance depend
Copays/coinsurance	on type and location of	depend on type and	Copays/coinsurance	Copays/coinsurance	on type and location of
depend on type and	service provided. \$20,000	location of service	depend on type and	depend on type and	service provided. \$20,000
location of service	lifetime maximum benefit.	provided. \$20,000 lifetime	location of service	location of service	lifetime maximum benefit.
provided. \$20,000 lifetim	e	maximum benefit.	provided. \$20,000	provided. \$20,000 lifetime	Plan will pay up to \$10k
maximum benefit.		Plan will pay up to \$10k	lifetime maximum	maximum benefit. Plan	travel and lodging allowance
		travel and lodging	benefit. Plan will pay up to	will pay up to \$10k travel	if service not available
		allowance if service is not		and lodging allowance if	within 100 miles of your
		available within 100 miles		service is not available	residence.
		of your residence.	available within 100 miles	within 100 miles of your	
			of your residence.	residence.	

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
Hearing Aids (per ear, ev	ery 36 months)	•			
Up to \$1,000	Up to \$1,000	Paid 80% no deductible up Paid 80% no deductible to \$1,500 per ear max.  In-network coinsurance applies whether purchased in- or out-of-network.  Deductible does not apply.			
Home Health Care					
Paid at 100% when authorized. No visit limit	Paid at 100% when authorized. No visit limit	Paid at 80% after deductible. Maximum benefit of 130 for in- and out-of-n			Paid at 60% after deductible. 30 visits per calendar year -network combined
Hospital Inpatient					
Paid at 100% after \$200 copay per admission	Paid at 100% after deductible	Facility: Paid at 80% after \$200 copay; no deductible.	•	Facility: Paid at 90% after \$200 copay; no deductible.	Facility: Paid at 60% after \$200 copay; no deductible.
Hospital Outpatient					
Paid at 100% after \$15 copay <b>Hospice</b>	\$15 copay Deductible applies	Facility: Paid at 80% after deductible.	Facility: Paid at 60% after deductible.	Facility: Paid at 90% after deductible.	Facility: Paid at 60% after deductible.
Paid at 100% when authorized  Maternity Care (delivery	Paid at 100% when authorized	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 90% after deductible.	Not covered
Paid at 100% after \$200 copay per admission	Deductible applies.	Facility: Paid at 80% after \$200 copay; copay waived for newborn hospital services. No deductible.	Facility: Paid at 60% after \$200 copay; copay waived for newborn hosp. services. No deductible.		Facility: Paid at 60% after \$200 copay; copay waived for newborn hosp. services. No deductible.
Maternity Care (prenatal	and postpartum)				
Paid at 100% after \$15 copay Routine care not subject	\$15 copay Deductible applies. Routine care not subject to	Other: Paid at 80% after deductible.	Other: Paid at 60% after deductible.	Other: Deductible and coinsurance may apply.	Other: Paid at 60% after deductible.
to outpatient services copay.	•	Pre-Natal (such as office visits):100% no copay, no deductible.	Pre-Natal (such as office visits): 60% after deductible.	,	Pre-Natal (such as office visits): 60% after deductible.

Deductible Plan rmanente*  Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<u> </u>	City of Seattle T			Jul J. Helwork
Deductible Plan	orty or ocutile in	raditional Plan*	City of Seattle Preventive Plan*	
	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
ient)				
Paid at 100% after	Paid at 80% after \$200	Paid at 60% after \$200	Paid at 90% after \$200	Paid at 60% after \$200
deductible	copay; no deductible.	copay; no deductible.	copay; no deductible.	copay; no deductible.
	Review and coordination of care in complex situations, including residential treatment centers		including residential trea	of care in complex situations, atment centers and partial alization.
atient)				
15 copay per session. Deductible applies.	Paid at 80% after deductible.			Paid at 60% after deductible.
	Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.		a behavioral health provider by web, phone, or	
	in complex situations, inclu	ding psychological testing,	complex situations, inclu	and coordination of care in ding psychological testing, and intensive outpatient.
2-1-1-1-1-000/	D. 1.1. 1. 000/ - ft	Daid at COOK after	D.1.1.1.4000/ - () 645	Database COOK a file a
Paid at 100% after 515 copay. Deductible applies	Paid at 80% after deductible (waived for preventive care).	deductible.	copay per visit (waived for	Paid at 60% after deductible.
	physician by web, phone, or mobile device for selected short-term services through	r	medical consultation with a physician by web, phone, o mobile device for selected short-term services through	r
	Paid at 100% after deductible  atient)  515 copay per session.  Deductible applies.  Paid at 100% after 615 copay.	Paid at 80% after \$200 copay; no deductible.  Review and coordinati situations, including resid and partial horatient)  Paid at 80% after deductible.  Paid at 80% after deductible.  Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.  Additional focus on review in complex situations, incluneurological testing, and the deductible applies  Paid at 80% after deductible (waived for preventive care).  Additional access to medical consultation with a physician by web, phone, o mobile device for selected	Paid at 80% after \$200 Paid at 60% after \$200 copay; no deductible.  Review and coordination of care in complex situations, including residential treatment centers and partial hospitalization.  Paid at 80% after Paid at 80% after deductible.  Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.  Additional focus on review and coordination of care in complex situations, including psychological testing, neurological testing, and intensive outpatient.  Paid at 80% after Paid at 60% after deductible deductible deductible deductible deductible deductible deductible waived for deductible.  Paid at 80% after Paid at 60% after deductible deductible (waived for deductible).  Additional access to medical consultation with a physician by web, phone, or mobile device for selected short-term services through	Paid at 100% after deductible  Paid at 80% after \$200 copay; no deductible.  Review and coordination of care in complex situations, including residential treatment centers and partial hospitalization.  Paid at 80% after Paid at 80% after deductible.  Paid at 100% after Paid at 80% after deductible.  Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.  Additional focus on review and coordination of care in complex situations, including residential treatment centers and partial hospitalization.  Paid at 80% after Paid at 80% after Paid at 100% after \$15 copay; no deductible.  Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.  Additional focus on review and coordination of care in complex situations, including psychological testing, neurological testing, and intensive outpatient.  Paid at 100% after Paid at 60% after deductible (waived for deductible.  Paid at 100% after Paid at 60% after deductible (waived for preventive care).  Additional access to medical consultation with a physician by web, phone, or mobile device for selected short-term services through

Kaiser P	ermanente*	City of Seattle Traditional 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 (reta	il)	•	1	-1	-
For a 30-day supply:	For a 30-day supply:	Retail: 31-day supply	Not covered.	Retail: 31-day supply	Not covered.
Generic: \$15 copay.	Generic: \$15 copay.				
Generic contraceptive	Generic contraceptive	Health Care Reform (HCR):		Health Care Reform (HCR):	
drugs paid at 100%.	drugs paid at 100%.	certain preventive drugs		certain preventive drugs	
Brand: \$30 copay	Brand: \$30 copay	covered at 100%.		covered at 100%.	
Brand contraceptive	Brand contraceptive drugs	5			
drugs and devices subject	ct and devices subject to	Generic: 30% coinsurance		Generic: 30% coinsurance	
to copay	copay	<b>Brand</b> : 40% coinsurance		Brand: 40% coinsurance	
		The per script minimum		The per script minimum	
		coinsurance is \$10, or actual		coinsurance is \$10, or actual	
		cost of the drug if less.		cost of the drug if less.	
		Maximum is \$100 per drug.		Maximum is \$100 per drug.	
Smoking cessation	Smoking cessation	Coinsurance applies to the p	rescription drug \$1,20	00 out-of-pocket annual maximu	m per person, \$3,600 per
prescription drugs not	prescription drugs not	family. Certain Health Care R	Reform preventive gen	eric and brand drugs covered at	100% with a prescription
subject to	subject to	including contraceptives, sta	tins, and HIV. Prescrip	tion Allowance on all non-sedat	ing antihistamines (for
pharmacy copay.	pharmacy copay.	allergy symptoms) and Proto	on Pump Inhibitors (for	r heartburn relief and ulcer treat	ment). City pays \$20 per
		month, and plan participant	pays remaining; some	over-the-counter medications a	re also included. \$5 copay
		for generic diabetic drugs an	d supplies, \$15 copay	for brand. Coinsurance for asthr	ma, anti-high cholesterol, and
		tobacco cessation drugs 10%	for generic and 20% f	for brand pharmacy.	
Prescription Drugs (mail	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 supp	ly Not Covered.
Generic: \$45 copay.	Generic: \$30 copay.	supply (32-90 day supply)		(32-90 day supply)	
Generic contraceptive	Generic contraceptive				
drugs paid at 100%.	drugs paid at 100%.	Health Care Reform (HCR):		Health Care Reform (HCR):	
Brand: \$90 copay	Brand: \$60 copay	certain preventive drugs		certain preventive drugs	
Contraceptive drugs and	l devices are covered	covered at 100%.		covered at 100%.	
subject to the pharmacy	copay.	Generic: 30% coinsurance		Generic: 30% coinsurance	
		<b>Brand</b> : 40% coinsurance		Brand: 40% coinsurance	
		The per script minimum is		The per script minimum is \$20	
		\$20; the maximum is		the maximum is \$200 per drug	•
		\$200 per drug.			

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
Preventive and Wellnes	s Services	•	•		•
Paid at 100% after	Paid at 100% after	Paid at 100% Services	Deductible and	Paid at 100% Services	Deductible and coinsurance
\$15 copay	\$15 copay	recommended by the <u>U.S.</u>	coinsurance may	recommended by the <u>U.S.</u>	may apply.
		Preventive Services Task	apply.	Preventive Services Task Force	
		Force (USPSTF). Includes		(USPSTF).	
		routine adult physical and		Includes routine adult physical	
		well-child exams,		and well-child exams,	
		immunizations, digital recta		immunizations, digital rectal	
		exams/prostate-specific		exams/prostate-specific antige	า
		antigen test, lactation		test, lactation consultation, and	l
		consultation, and breast and	t	breast and colorectal cancer	
		colorectal cancer		screenings.	
		screenings.			
<b>Rehabilitation Services</b>	(inpatient)				
Paid at 100% after \$200	Paid at 100% after	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after
copay per admission	deductible.	\$200 copay; no deductible.	\$200 copay; no ded.	\$200 copay; no deductible.	\$200 copay; no deductible.
Maximum of 60 d	ays per calendar year			Maximum of 120 days per cale	endar year for skilled nursing
(combined with o	ther therapy benefits)			and rehab services in- and o	out-of-network combined
Rehabilitation Services	(outpatient)				
Paid at 100% after	\$15 copay	Paid at 80% after deductible	. Paid at 60% after	Paid at 100% after	Paid at 60% after
\$15 copay	Deductible applies.		deductible.	\$15 copay; no deductible.	deductible.
Maximum of 60 v	isits per calendar year	Twenty-five visits per cale	ndar year for physical,	Twenty-five visits per calendar year for physical, massage	
(combined with o	ther therapy benefits)	massage and occupation	nal therapy includes	and occupational therapy includes outpatient hospital	
		outpatient hospital services	s. Additional visits may	services. Additional visits n	nay be covered if deemed
		be covered if deemed n	nedically necessary.	medically n	ecessary.
Skilled Nursing Facility					
Paid at 100%. 60-day	Paid at 100% after	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after
maximum per	deductible. 60-day	\$200 copay; no deductible.	\$200 copay; no	\$200 copay; no deductible.	\$200 copay; no deductible.
calendar year.	maximum per calendar		deductible.		
	year.	Maximum of 90 days pe	r calendar year for	Maximum of 120 days per cale	endar year for rehab services
		in- and out-of-netw	vork combined	and skilled nursing in- and o	out-of-network combined

Kaiser Pe	rmanente*	City of Seattle Trac	litional Plan*	City of Seattle Preventive Plan*		
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network	
Smoking Cessation		•				
Paid at 100%	Paid at 100%	Lifetime maximum of		Smoking cessation	Not covered	
for individual	for individual	one 90-day supply		prescription drugs covered		
or group sessions	or group sessions	of aids or drugs.		subject to 10% generic, 20%		
Nicotine replacement the	rapy included in	Coinsurance 10% generic,		brand drug coinsurance.		
Prescription Drug benefit		20% brand. See Prescription				
		Drugs.				
<b>Spinal Manipulations</b> (ch	iropractic)					
Paid at 100% after	\$15 copay.	Paid at 80% after	Paid at 60% after	Paid at 100% after	Paid at 60% after deductible.	
\$15 copay	Deductible applies.	deductible.	deductible.	\$15 copay; no deductible.		
Self-referral to Kaiser	Permanente designated	Maximum of 10 visits per calendar year		Maximum of 20 visits per calendar year		
1'	iser Permanente protocol. its per calendar year.	for in-network and out-of	-network combined.	for in-network and out-	of-network combined.	
Sterilization Procedures						
Inpatient: Paid at 100%	Inpatient: Paid at 100%	Inpatient: Paid at	Inpatient: Paid at 60%	Inpatient: Paid at	Inpatient: Paid at 60% after	
after \$200 copay		80% after \$200 copay.	after \$200 copay.	90% after \$200 copay; no ded.	\$200 copay; no deductible.	
Outpatient: Paid at 100%	Outpatient: \$15 copay	Outpatient: Paid at 80%	Outpatient: Paid	Outpatient: Paid at 90% after	Outpatient: Paid	
after \$15 copay	Deductible applies	after deductible.	at 60% after deductible.	deductible.	at 60% after deductible.	
		Tubal ligation: 100% no	academore.	Tubal ligation: 100% no copay;		
		copay; no deductible.		no deductible.		
Temporomandibular Join	t Services					
Covered as any	Covered as any	Covered as any	Covered as any	Covered as any	Covered as any	
other service;	other service;	other service;	•	other service;	other service;	
copays/coinsurance	copays/coinsurance	copays/coinsurance depend	•	copays/coinsurance depend or	•	
depend on type and	depend on type and	on type and location of	• • •	type and location of service	on type and location of	
location of service	location of service	service provided.	location of service	provided.	service provided.	
provided.	provided.		provided.			
		\$5,000 lifetime maximum for in- and out-of-netw		\$5,000 lifetime maximum for out-of-netwo	_	

Kaiser Po	ermanente*	City of Seattle Traditional Plan*		City of Seattle Pr	eventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network	
Tooth Injury/Oral Surge	ry (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	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.	Outpatient: Paid at 60%	
				Other charges paid at 90%		
Vision Exam/Hardware						
Exam: Paid at	Exam: Paid at 100% after	Covered und	Covered under VSP.		Covered under VSP.	
100% after \$15 copay.	\$15 copay.					
One exam every	One exam every					
12 months.	12 months.					
Hardware:	Hardware is not covered.					
Not covered.						
X-ray and Lab Tests		•		•		
Paid at 100%	Paid at 100%	Paid at 80% after	Paid at 60% after	Paid at 90% after deductible.	Paid at 60% after deductible.	
	Deductible applies	deductible.	deductible.			
				Provider responsible for		
		Provider responsible for		obtaining precertification of		
		obtaining precertification of	:	high-tech radiology		
		high-tech radiology		<b>3</b> .		

<sup>\*</sup> 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 seattle.gov/human-resources/benefits/employees-and-covered-family-members. 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.