2024 Medical Plans Comparison – "Most" City of Seattle 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://bit.ly/SCERSret1.

Kaiser P	ermanente*	City of Seattle 1	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 me	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 th	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 N	Maximum (OOP Max) includ	des medical coinsurance	. The OOP Max includes t	he deductible and exclu	des prescription drug
copays/coinsurance.					
Includes m	edical 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 or	emergency admissions,	Except for maternity	or emergency admissions,
must be authorized	by Kaiser Permanente	your physician must co	ntact Aetna before your	your physician must o	contact Aetna before your
		admission. The mem	ber is responsible for	admission. The member is responsible for	
		obtaining precertification of out-of-network		obtaining precertification of out-of-network care.	
		ca	re.		

Kaiser P	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		·	•	•			
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.		
when approved.	when approved. Deductible applies.	out-of-netwo	rk combined	network	combined		
Alcohol/Drug Abuse Ti	• •						
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 per admission	deductible	copay; no deductible.	copay; no deductible.	copay; no deductible.	copay; no deductible.		
			ion of care in complex residential treatment al hospitalization	Review and coordination of care in complex situations, including residential treatment centers and partial 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	Paid at 100% after \$15 co-	Paid at 80% after	Paid at 60% after	Paid at 100% after \$15	Paid at 60% after
copay	pay Deductible applies	deductible.	deductible.	copay.	deducible.
		Additional focus on re	view and coordination of		view and coordination of
		•	situations, including	•	ns, including psychological
			neurological testing, and		I testing, and intensive
		intensive	outpatient.	outp	oatient.
Contraceptives					
•	e drugs and devices,	•	Provera covered as	·	Provera covered as
see Prescript	ion Drug benefit		o charge for preferred		charge for preferred
		<u> </u>	pproved women's	generic FDA-approved women's	
		contraceptives in-network.		contraceptives in-network.	
		Soo Droscripti	on Drug benefit.	Saa Drascrinti	on Drug benefit.
Durable Medical Equip	mont	See Plescripti	on Drug benefit.	See Flescription	on Drug benefit.
Paid at 80%	Paid at 80%	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after
raiu at 60%	rdiu at 60%	deductible.	deductible.	deductible.	deductible.
		deductible.	deductible.	deductible.	deddelible.
		Breast pumps covered		Breast pumps covered	
		as preventive care at		as preventive care at	
		100% no deductible		100% no deductible	
		through DME provider		through DME provider.	
		Includes 1 electric bre	east pump per 12 months	Includes 1 electric bre	ast 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		If non-emergency, paid a	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	sportation only covered if
		approved in advance by	Aetna. Deductible does	approved in advance by Aetna. Deductible does	
		not a	oply.	not	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 Traditional 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. \$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
				within 100 miles of your residence.	
		miles of your residence.	or your residence.	residence.	
Hearing Aids (per ear, e	very 36 months)				
Up to \$1,000	Up to \$1,000	Paid 80% no deductible	Paid 80% no deductible	Paid 90% no deductible	Paid 90% no deductible
		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.
		max.	max.	max.	
		In-network coinsurar	nce applies whether	In-network coinsurance	applies whether purchased
		purchased in- or o	out-of-network.		of-network.
		Deductible do	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	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-n	etwork combined	for in- and out-of	-network combined

Kaiser I	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	
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	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.	•		
		deductible.		deductible.		
Maternity Care (prena		•				
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.	copay.	visits):100% no copay, no	•	visits):100% no copay,	visits): 60% after	
		deductible.	deductible.	no deductible.	deductible.	
Mental Health Care (ir	•					
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 coordinati	•		ntion of care in complex	
		situations, including r			idential treatment centers	
		centers and partia	al hospitalization.	and partial l	nospitalization.	
Mental Health Care (outpatient)						

Kaiser I	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 through	า	provider by web, phone,	
		Teladoc also available.		or mobile device through	1
				Teladoc also available.	
		Additional focus on rev	iew and coordination of	Additional focus on review and coordination of	
		care in complex situations, including		care in complex situations, including psychological	
		psychological testing, n	eurological testing, and	testing, neurological testing, and intensive	
		intensive o	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		phone, or mobile device	
		for selected short-term		for selected short-term	
		services through Teladoo		services through Teladoc	
		also available.		also available.	

Kaiser Pe	rmanente*	City of Seattle Traditional Plan* City of Seattle Prevent		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	• •	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.	Coinsurance applies to the prescription drug \$1,200 out-of-pocket annual maximum per person,			

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Pre	City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network	
Prescription Drugs (ma	il 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 an	d devices are covered	Generic: 30% coinsurance		Generic: 30% coinsurance		
subject to the pharmac	y copay.	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						
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>U.S.</u>	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	,	
		immunizations, digital		immunizations, digital rectal		
		rectal exams/prostate-		exams/prostate-specific		
		specific antigen test,		antigen test, lactation		
		lactation consultation, and		consultation, and breast and		
		breast and colorectal		colorectal cancer screenings.		
		cancer screenings.				
Rehabilitation Services	· · ·	T				
Paid at 100% after			Paid at 60% after	Paid at 90% after	Paid at 60% after	
\$200 copay per	deductible.	1 · · · · · · · · · · · · · · · · · · ·	\$200 copay; no ded.	\$200 copay; no deductible.	\$200 copay; no	
admission		deductible.			deductible.	
	ys per calendar year			Maximum of 120 days per of	•	
(combined with oth	ner therapy benefits)			nursing and rehab services		
				combin	ed	

Kaiser Pe	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
Rehabilitation Services	(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		,	,	•	
Paid at 100%. 60-day maximum per calendar year. Smoking Cessation Paid at 100% for individual	Paid at 100% after	Paid at 80% after \$200 copay; no deductible. Maximum of 90 days pe in- and out-of-netv Lifetime maximum of one 90-day supply	•	Paid at 90% after \$200 copay; no deductible. Maximum of 120 days pe services and skilled nursir comb Smoking cessation prescription drugs covered	deductible. r calendar year for rehab ng in- and out-of-network
or group sessions Nicotine replacement t Prescription Drug bene	fit	of aids or drugs.		subject to 10% generic, 20% brand drug coinsurance.	
Spinal Manipulations (Doid at 000/ -ft	Doid at COO/ after	Paid at 100% after	Paid at 60% after
Paid at 100% after \$15 copay	\$15 copay. Deductible applies.	Paid at 80% after deductible.	Paid at 60% after deductible.	\$15 copay; no deductible.	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 visit for in-network and out-	•

Kaiser Pe	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
Sterilization Procedure	es	-			
Inpatient: Paid at 100% after \$200 copay	6 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	Outpatient: Paid at 60% after deductible.
	-1-1-01			copay; no deductible.	
Temporomandibular J		1		T .	
Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance	Covered as any other service; copays/coinsurance depend	Covered as any other service; copays/coinsurance
depend on type and location of service provided.	depend on type and location of service provided.	depend on type and 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-	um for non-surgical	\$5,000 lifetime maximum f and out-of-netv	or non-surgical services in-
Tooth Injury/Oral Surg	gery (due to accident)	T			
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. Other charges paid at 90%	Outpatient: Paid at 60%

Kaiser Per	Kaiser Permanente*		itional Plan*	onal Plan* City of Seattle Preventive Plan*		
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-	Aetna In-Networl	k Out-of-Network	
			Network			
Vision Exam/Hard	lware					
Exam: Paid at	Exam: Paid at	Routine Exam: Paid	at 100% once	Not covered.	Not covered.	
100% after \$15	100% after a \$15	per calenda	r year			
copay. One exam	copay.	Hardware: Two	lenses per			
every	One exam every	calendar y	ear;			
12 months.	12 months.	The lenses are between	een \$40 - \$130			
Hardware:	Hardware: Not	Single vision lens :	\$40 per lens			
Not covered.	covered.	Bifocal vision lens	\$60 per lens			
		Trifocal vision lens	\$80 per lens	Hardware: Not covered. Discounts at:		
		Lenti vision lens \$	130 per lens	eyemedvisioncare.com/memb	oer/public/discountPlans.emvc?execution=e1s2	
		Frames; \$30 ever	y other year			
X-ray and Lab Tes	ts					
Paid at 100%	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%	
	Deductible	Provider responsible		Provider responsible for ob	otaining	
	applies	for obtaining		precertification of high-tec	ch 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.

Plan details are in your medical plan booklet at https://bit.ly/SCERSret1. This document is not a contract.

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.