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 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 Preventive Plan***	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
No Deductible	$200 per person $600 per family Deductible applies as noted except for prescriptions, preventive visits, ambulance, and durable medical equipment.	$450 per person $1,350 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$1,000 per person $3,000 per family	$100 per person $300 per family Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) includes medical coinsurance. The OOP Max includes the deductible and excludes prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,450 per person $4,350 per family	$2,000 per person** $6,000 per family*	$2,000 per person $4,000 per family	$3,000 per person* $6,000 per family*
Hospital Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by Kaiser Permanente		Except for maternity or emergency admissions, your physician must contact Aetna before your admission. The member is responsible for obtaining precertification of out-of-network care.		Except for maternity or emergency admissions, your physician must contact Aetna before your admission. The member is responsible for obtaining precertification of out-of-network care.	

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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.	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 year. Additional visits when approved.	$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits when approved. Deductible applies.	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 100% after $15 copay.	Paid at 60% after deductible.
		Up to 12 visits per calendar year in- and out-of-network combined		Up to 20 visits per calendar year in- and out-of-network combined	
Alcohol/Drug Abuse Treatment (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 situations, including residential treatment centers and partial hospitalization	

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Alcohol/Drug Abuse Treatment (outpatient)					
Paid at 100% after $15 copay	Paid at 100% after $15 co-pay Deductible applies	Paid at 80% after deductible. Additional focus on review and coordination of care in complex situations, including psychological testing, neurological testing, and intensive outpatient.	Paid at 60% after deductible.	Paid at 100% after $15 copay. Additional focus on review and coordination of care in complex situations, including psychological testing, neurological testing, and intensive outpatient.	Paid at 60% after deducible.
Contraceptives					
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. See Prescription Drug benefit.		IUDs and Depo Provera covered as medical benefits. No charge for preferred generic FDA-approved women's contraceptives in-network. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80% after deductible. Breast pumps covered as preventive care at 100% no deductible through DME provider. Includes 1 electric breast pump per 12 months	Paid at 60% after deductible.	Paid at 90% after deductible. Breast pumps covered as preventive care at 100% no deductible through DME provider. Includes 1 electric breast pump per 12 months	Paid at 60% after deductible.
Emergency Medical Care					
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 (copays 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.	Paid at 80% 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.	Paid at 90% after $150 copay; no deductible. If non-emergency, paid at 60% after copay.

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Ambulance					
Paid at 80%.	Paid at 80%.	Paid at 80% when medically necessary. Non-emergency transportation only covered if approved in advance by Aetna. Deductible does not apply.		Paid at 90% when medically necessary. Non-emergency transportation only covered if approved in advance by Aetna. Deductible does not apply.	
Gender Reassignment Services					
Covered as any other service; copays/coinsurance depending 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. Plan will pay up to $10k travel and lodging allowance if service not available within 100 miles of your residence.	Covered as any other service; copays/coinsurance depend on type and location of service provided. Plan will pay up to $10k travel and lodging allowance if service not available within 100 miles of your residence.	Covered as any other service; copays/coinsurance depend on type and location of service provided. Plan will pay up to $10k travel and lodging allowance if service not available within 100 miles of your residence.	Covered as any other service; copays/coinsurance depend on type and location of service provided. Plan will pay up to $10k travel and lodging allowance if service not available within 100 miles of your residence.
Fertility Services					
Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit.	Procedures covered include artificial insemination, ovulation induction, and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit.	Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit. Plan will pay up to $10k travel and lodging allowance if service is not available within 100 miles of your residence.	Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit. Plan will pay up to $10k travel and lodging allowance if service is not available within 100 miles of your residence.	Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit. Plan will pay up to $10k travel and lodging allowance if service is not available within 100 miles of your residence.	Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. $20,000 lifetime maximum benefit. Plan will pay up to $10k travel and lodging allowance if service not available within 100 miles of your residence.

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Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Paid 80% no deductible up to $1,500 per ear max. In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Paid 80% no deductible up to $1,500 per ear max.	Paid 90% no deductible up to $1,500 per ear max. In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Paid 90% no deductible up to $1,500 per ear max.
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 visits per calendar year for in- and out-of-network combined	Paid at 60% after deductible.	Paid at 90% after deductible. Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60% after deductible.
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 60% 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	$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.
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 90% after deductible.	Not covered
Maternity Care (delivery & related hospital)					
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 90% 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.
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay Routine care not subject to outpatient services copay.	$15 copay Deductible applies. Routine care not subject to outpatient services copay.	Other: Paid at 80% after deductible. Pre-Natal (such as office visits):100% no copay, no deductible.	Other: Paid at 60% after deductible. Pre-Natal (such as office visits): 60% after deductible.	Other: Deductible and coinsurance may apply. Pre-Natal (such as office visits):100% no copay, no deductible.	Other: Paid at 60% after deductible. Pre-Natal (such as office visits): 60% after deductible.

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Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Mental Health Care (inpatient)					
Paid at 100% after $200 copay	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 60% after $200 copay; no deductible.	Paid at 90% after $200 copay; no deductible. Review and coordination of care in complex situations, including residential treatment centers and partial hospitalization.	Paid at 60% after $200 copay; no deductible.
Mental Health Care (outpatient)					
Paid at 100% after $15 copay per session.	$15 copay per session. Deductible applies.	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 deductible.	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 60% after deductible.
Physician Office Visit					
Paid at 100% after $15 copay.	Paid at 100% after $15 copay. Deductible applies	Paid at 80% 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 Teladoc also available.	Paid at 60% after deductible.	Paid at 100% after $15 copay per visit (waived for preventive care). Additional access to medical consultation with a physician by web, phone, or mobile device for selected short-term services through Teladoc also available.	Paid at 60% after deductible.

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Prescription Drugs (retail)					
For a 30-day supply: **Generic**: $15 copay. Generic contraceptive drugs paid at 100%. **Brand:** $30 copay Brand contraceptive drugs and devices subject to copay	For a 30-day supply: **Generic**: $15 copay. Generic contraceptive drugs paid at 100%. **Brand:** $30 copay Brand contraceptive drugs and devices subject to copay	**Retail:** 31-day supply **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.	Not covered.	**Retail:** 31-day supply **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.	Not covered.
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, $3,600 per family. Certain Health Care Reform preventive generic and brand drugs covered at 100% with a prescription including contraceptives, statins, and HIV. Prescription Allowance on all non-sedating antihistamines (for allergy symptoms) and Proton Pump Inhibitors (for heartburn relief and ulcer treatment). City pays $20 per month, and plan participant pays remaining; some over-the-counter medications are also included. $5 copay for generic diabetic drugs and supplies, $15 copay for brand. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.			
Prescription Drugs (mail order)					
For a 90-day supply: **Generic**: $45 copay. Generic contraceptive drugs paid at 100%. **Brand:** $90 copay	For a 90-day supply: **Generic**: $30 copay. Generic contraceptive drugs paid at 100%. **Brand:** $60 copay	**Mail Order:** up to 90-day supply (32-90 day supply) **Health Care Reform (HCR)**: certain preventive drugs covered at 100%. **Generic**: 30% coinsurance **Brand**: 40% coinsurance The per script minimum is $20; the maximum is $200 per drug.	Not Covered.	**Mail Order:** up to 90-day supply (32-90 day supply) **Health Care Reform (HCR)**: certain preventive drugs covered at 100%. **Generic**: 30% coinsurance **Brand:** 40% coinsurance The per script minimum is $20; the maximum is $200 per drug.	Not Covered.
Contraceptive drugs and devices are covered subject to the pharmacy copay.					

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Preventive and Wellness Services					
Paid at 100% after $15 copay	Paid at 100% after $15 copay	Paid at 100% Services recommended by the U.S. Preventive Services Task Force (USPSTF). Includes routine adult physical and well-child exams, immunizations, digital rectal exams/prostate-specific antigen test, lactation consultation, and breast and colorectal cancer screenings.	Deductible and coinsurance may apply.	Paid at 100% Services recommended by the U.S. Preventive Services Task Force (USPSTF). Includes routine adult physical and well-child exams, immunizations, digital rectal exams/prostate-specific antigen test, lactation consultation, and breast and colorectal cancer screenings.	Deductible and coinsurance may apply.
Rehabilitation Services (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 ded.	Paid at 90% after $200 copay; no deductible.	Paid at 60% after $200 copay; no deductible.
Maximum of 60 days per calendar year (combined with other therapy benefits)				Maximum of 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined	
Rehabilitation Services (outpatient)					
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.
Maximum of 60 visits per calendar year (combined with other therapy benefits)		Twenty-five visits per calendar year for physical, massage and occupational therapy includes outpatient hospital services. Additional visits may be covered if deemed medically necessary.		Twenty-five visits per calendar year for physical, massage and occupational therapy includes outpatient hospital services. Additional visits may be covered if deemed medically necessary.	
Skilled Nursing Facility					
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.	Paid at 60% after $200 copay; no deductible.	Paid at 90% after $200 copay; no deductible.	Paid at 60% after $200 copay; no deductible.
		Maximum of 90 days per calendar year for in- and out-of-network combined		Maximum of 120 days per calendar year for rehab services and skilled nursing in- and out-of-network combined	

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Smoking Cessation					
Paid at 100% for individual or group sessions Nicotine replacement therapy included in Prescription Drug benefit	Paid at 100% for individual or group sessions	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
Spinal Manipulations (chiropractic)					
Paid at 100% after $15 copay Self-referral to Kaiser Permanente designated providers. Must meet Kaiser Permanente protocol. Maximum of 10 visits per calendar year.	$15 copay. Deductible applies.	Paid at 80% after deductible. Maximum of 10 visits per calendar year for in-network and out-of-network combined.	Paid at 60% after deductible.	Paid at 100% after $15 copay; no deductible. Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60% after deductible.
Sterilization Procedures					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 100% Outpatient: $15 copay Deductible applies	Inpatient: Paid at 80% after $200 copay. Outpatient: Paid at 80% after deductible. Tubal ligation: 100% no copay; no deductible.	Inpatient: Paid at 60% after $200 copay. Outpatient: Paid at 60% after deductible.	Inpatient: Paid at 90% after $200 copay; no ded. Outpatient: Paid at 90% after deductible. Tubal ligation: 100% no copay; no deductible.	Inpatient: Paid at 60% after $200 copay; no deductible. Outpatient: Paid at 60% after deductible.
Temporomandibular Joint 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 maximum for non-surgical services in- and out-of-network combined	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 maximum for non-surgical services in- and out-of-network combined	Covered as any other service; copays/coinsurance depend on type and location of service provided.

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Tooth Injury/Oral Surgery (due to accident)					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80% after deductible.	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60% after deductible.	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Vision Exam/Hardware					
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 under VSP.		Covered under 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 60% after deductible.	Paid at 90% after deductible. Provider responsible for obtaining precertification of high-tech radiology	Paid at 60% after deductible.

* 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 find providers; dealing with billing, claim and appeals problems; understanding diagnoses and treatment options, and managing chronic diseases.

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**