## **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	
<b>Deductible</b> (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	k				
	except for prescriptions,	Deductible applies to mo	st services, except as noted.	Deductible applies to me	ost services, except as noted.	
	preventive visits,	Deductible does not appl	y for prescriptions or when	Deductible does not app	oly for prescriptions or when the	
	ambulance, and durable	the Inpatient co-pay or e	mergency room co-pay	Inpatient co-pay or eme	rgency room co-pay applies.	
	medical equipment.	applies.				
Annual Out of Pocket N	Maximum (OOP Max) includes	medical coinsurance. The	OOP Max includes the deduc	tible and excludes prescr	iption 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	
<b>Hospital Pre-admission</b>	Authorization					
Except for maternity	y or emergency admissions,	Except for maternity or e	emergency admissions, your	Except for maternity of	or emergency admissions, your	
must be authorize	ed by Kaiser Permanente	physician must contact A	etna before your admission.			
		The member is res	ponsible for obtaining	The member is r	esponsible for obtaining	
		precertification of out-of-network care.		precertification	of out-of-network care.	

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
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.	, , ,	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	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	•	· ·	ar year in- and out-of-network
Alcohol/Drug Abuse Tre		out-of-netwo	rk combined	CO	mbined
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.
admission		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	

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						
For contraceptive	ve drugs and devices, tion 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 Prescript	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.		Breast pumps covered as preventive care at 100% no deductible through DME provider.	
		Includes 1 electric bre	Includes 1 electric breast pump per 12 months		east pump per 12 months	
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 (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.	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.	

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					
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 no apply.	
Gender Reassignment Se	rvices	μ	7.	<u> </u>	, , , , , , , , , , , , , , , , , , ,
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.		copays/coinsurance depend on type and location of service provided. Plan will pay up to \$10k travel and lodging allowance if	to \$10k travel and lodging allowance if service not available within 100 miles	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		<u> </u>			
Procedures covered include artificial insemination, ovulation induction and Advanced Reproductive Technologies. Copays/coinsurance depend on type and location of service provided. \$20,000 lifetim maximum benefit.	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.	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	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.

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
Hearing Aids (per ear, ev	ery 36 months)				
Up to \$1,000			to \$1,500 per ear max. up to \$1,500 per ear max. to		Paid 90% no deductible up to \$1,500 per ear max. pplies whether purchased inf- f-network. 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	\$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					
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.	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.

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
Kaiser I	Permanente*	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
Mental Health Care (inp	atient)				
Paid at 100% after \$200	Paid at 100% after	Paid at 80% after \$200	Paid at 60% after \$200	Paid at 90% after \$200	Paid at 60% after \$200
copay	deductible	copay; no deductible.	copay; no deductible.	copay; no deductible.	copay; no deductible.
		Review and coordinati situations, including resid and partial ho	lential treatment centers	Review and coordination of care in complex situations, including residential treatment centers and partial hospitalization.	
Mental Health Care (out	patient)	•		•	
Paid at 100% after \$15 copay per session.	\$15 copay per session. Deductible applies.	Paid at 80% after deductible.	Paid at 80% after deductible.	Paid at 100% after \$15 copay; no deductible.	Paid at 60% after deductible.
		Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.		Ongoing consultation with a behavioral health provider by web, phone, or mobile device through Teladoc also available.	r
		in complex situations, inclu	Additional focus on review and coordination of care in complex situations, including psychological testing, neurological testing, and intensive outpatient.		v and coordination of care in Iding psychological testing, nd intensive outpatient.
Physician Office Visit	D : L + 4000/ ft	D : 1 + 000/ ft	D : 1 + COO( - 6:	D : 1 : 4000/ 6: 445	D : 1 + COO( - f)
Paid at 100% after \$15 copay.	Paid at 100% after \$15 copay. Deductible applies	Paid at 80% after deductible (waived for preventive care).	Paid at 60% after deductible.	Paid at 100% after \$15 copay per visit (waived for preventive care).	Paid at 60% after deductible.
		Additional access to medical consultation with a physician by web, phone, o mobile device for selected	1	Additional access to medical consultation with a physician by web, phone, o mobile device for selected	
		short-term services through Teladoc also available.	1	short-term services throug Teladoc also available.	h

Kaiser P	ermanente*	City of Seattle Traditional Plan*		City of Seattle Pr	reventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network	
Prescription Drugs (reta	il)	•	,	•	<u>'</u>	
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 drug	s				
drugs and devices subje	ct and devices subject to	Generic: 30% coinsurance		Generic: 30% coinsurance		
to copay	copay	Brand: 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	0 out-of-pocket annual maximu	m per person, \$3,600 per	
prescription drugs not	prescription drugs not	family. Certain Health Care R	deform 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 (fo	r heartburn relief and ulcer treat	tment). City pays \$20 per	
		month, and plan participant	pays remaining; some	over-the-counter medications a	are also included. \$5 copay	
		for generic diabetic drugs and supplies, \$15 copay for brand. Coinsurance for asthma, anti-high cholesterol, ar tobacco cessation drugs 10% for generic and 20% for brand pharmacy.				
Prescription Drugs (mai	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	devices are covered	covered at 100%.		covered at 100%.		
subject to the pharmacy	copay.	Generic: 30% coinsurance		Generic: 30% coinsurance		
		Brand: 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	<b>.</b>	
		\$200 per drug.				

Kaiser P	ermanente*	City of Seattle Tra	ditional Plan*	City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Preventive and Wellnes	ss 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	I	immunizations, digital rectal	
		exams/prostate-specific		exams/prostate-specific antiger	
		antigen test, lactation		test, lactation consultation, and	
		consultation, and breast and	d	breast and colorectal cancer	
		colorectal cancer		screenings.	
		screenings.			
Rehabilitation Services	(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	lays 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	e. 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 service	s. Additional visits may	services. Additional visits n	nay be covered if deemed
		be covered if deemed n	nedically necessary.	medically n	ecessary.
<b>Skilled Nursing Facility</b>					
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	er 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	ditional Plan*	City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Smoking Cessation		•			1
Paid at 100%	Paid at 100%	Lifetime maximum of	Not covered	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.			
Spinal Manipulations (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	
providers. Must meet Kaiser Permanente protocol.  Maximum of 10 visits 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		Tubal ligation: 100% no copay;	
		copay; no deductible.		no deductible.	
Temporomandibular Join	t Services	1 //			
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;	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	depend on type and	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 non-surgical services in- and out-of-network combined	

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
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	ler VSP.	Covered ur	nder 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	F	high-tech radiology	
		high-tech radiology			

<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.