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 Permanente*		City of Seattle 1	Traditional Plan*	City of Seattl	e Preventive Plan*
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Deductible (per calend	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 n	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	co-pay or emergency room
	durable medical	emergency room co-pay	/ applies.	co-pay applies.	
	equipment.				
Annual Out of Pocket I	Maximum (OOP Max) includ	des medical coinsurance	. The OOP Max includes	the deductible and exclu	des prescription drug
copays/coinsurance.					
Includes n	nedical copays	Excludes copays		Excludes copays	
\$2,000 per person	\$2,000 per person	\$1,450 per person	\$2,000 per person**	\$2,000 per person	\$3,000 per person*
\$4,000 per family	\$6,000 per family	\$4,350 per family	\$6,000 per family*	\$4,000 per family	\$6,000 per family*
Hospital Copay					
\$200 per admission	Deductible applies	\$200 copay	\$200 copay	\$200 copay	\$200 copay
		per admission	per admission	per admission	per admission
Hospital Pre-admission	n Authorization				
Except for maternity of	or emergency admissions,	Except for maternity or	r 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	contact Aetna before your
,		admission. The mem	nber is responsible for	admission. The me	ember is responsible for
		obtaining precertification of out-of-network		obtaining precertification of out-of-network care.	
		care.			

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
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			charges.		
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		,	,		
\$15 copay for up to 8 visits per medical diagnosis per calendar vear. 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.	Paid at 100% after \$15 copay.	Paid at 60% after deductible.
when approved.	when approved. Deductible applies.	out-of-netwo	•	· · · · · · · · · · · · · · · · · · ·	
Alcohol/Drug Abuse Ti	reatment (inpatient)			-	
Paid at 100% after \$200 copay per admission	Paid at 100% after deductible	Paid at 80% after \$200 copay; no deductible.	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 center and partial hospitalization	

Kaiser Permanente*		City of Seattle	Traditional Plan*	City of Seattle Preventive Plan*		
Standard Plan	Deductible Plan	Aetna In-Network	Aetna In-Network Out-of-Network		Out-of-Network	
Alcohol/Drug Abuse T	reatment (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	Additional focus on re	view and coordination of	
		· ·	situations, including	care in complex situatio	ons, including psychological	
		psychological testing,	neurological testing, and	testing, neurologica	I testing, and intensive	
		intensive	outpatient.	outp	oatient.	
Contraceptives						
For contraceptive	e drugs and devices,	IUDs and Depo F	Provera covered as	IUDs and Depo P	Provera covered as	
see Prescrip	tion Drug benefit		o charge for preferred		o charge for preferred	
			pproved women's	generic FDA-approved women's		
		contraceptiv	ves in-network.	contraceptiv	ves in-network.	
		See Prescripti	on Drug benefit.	See Prescripti	on Drug benefit.	
Durable Medical Equip	ment	·				
Paid at 80%	Paid at 80%	Paid at 80% after	Paid at 60% after	Paid at 90% after	Paid at 60% after	
		deductible.	deductible.	deductible.	deductible.	
		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	east pump per 12 months	
Emergency Medical Ca	re					
Urgent Care Clinic						
Paid at 100% after	\$15 copay	Paid at 80% after	Paid at 60% after	Paid at 100% after	Paid at 60% after	
\$15 copay	Deductible applies	deductible.	deductible.	\$15 copay; no deductible.	deductible.	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
Emergency Room (copa	ys waived if admitted)				
Kaiser Permanente	Kaiser Permanente facility:	Paid at 80% after	Paid at 80% after \$150	Paid at 90% after	Paid at 90% after
facility: \$100 copay	\$100 copay	\$150 copay; no	copay; no deductible.	\$150 copay; no	\$150 copay; no
Non-Kaiser Permanente	Non-Kaiser Permanente	deductible.	f non-emergency, paid	deductible.	deductible.
facility: \$150 copay	facility: \$150 copay	If non-emergency, paid 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 b	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 you	of your residence.
		residence.	your residence.	residence.	

Kaiser Permanente*		City of Seattle Traditional Plan*		City of Seattle	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 available within 100 miles	service is not available	within 100 miles of your	
		available within 100	of your residence.	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	
	l	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.	
	ı	max.	max.	max.		
		In-network coinsurar	nce applies whether	In-network coinsurance	applies whether purchased	
		purchased in- or o	out-of-network.	in- or out-	of-network.	
		Deductible do	es not apply.	Deductible o	does not apply.	
Home Health Care						
Paid at 100% when	Paid at 100%	Paid at 80% after	Paid at 60% after	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	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.	<u>'</u>	
		deductible.		deductible.	
Maternity Care (prena				•	
Paid at 100% after	\$15 copay	Other: Paid at 80% after		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 (in	•	·		,	
Paid at 100% after	Paid at 100% after	Paid at 80% 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	•		ation of care in complex
		situations, including r			idential treatment centers
		centers and partia	ai nospitalization.	and partial I	nospitalization.
Mental Health Care (o	utpatient)				

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

Kaiser Pe	Kaiser Permanente*		City of Seattle Traditional Plan*		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	• •	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		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.	drug. 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.				

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	
Prescription Drugs (ma	nil 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	cy 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	ess Services					
Paid at 100% after	Paid at 100% after	Paid at 100% Services	Deductible and	Paid at 100% Services	Deductible and	
\$15 copay	\$15 copay	recommended by the U.S.	coinsurance may	recommended by the <u>U.S.</u>	coinsurance may apply.	
		Preventive Services Task	apply.	Preventive Services Task		
		Force (USPSTF). Includes		Force (USPSTF).		
		routine adult physical and		Includes routine adult		
		well-child exams,		physical and well-child exams	,	
		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	s (inpatient)			•		
Paid at 100% after	Paid at 100% afte		Paid at 60% after	Paid at 90% after	Paid at 60% after	
\$200 copay per	deductible.	• • •	\$200 copay; no ded	.\$200 copay; no deductible.	\$200 copay; no	
admission		deductible.			deductible.	
	ys per calendar year			Maximum of 120 days per o		
(combined with oth	ner therapy benefits)			nursing and rehab services		
				combin	ed	

Kaiser Pe	Kaiser Permanente*		City of Seattle Traditional Plan*		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. Street		Paid at 100% after Paid at 60% 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 be covered if deemed medically necessary.	
Skilled Nursing Facility					
Paid at 100%. 60-day maximum per calendar year. Smoking Cessation Paid at 100% for individual or group sessions Nicotine replacement to Prescription Drug bene	deductible. 60-day maximum per calendar year. Paid at 100% for individual or group sessions herapy included in	Paid at 80% after \$200 copay; no deductible. Maximum of 90 days pe in- and out-of-netw Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic 20% brand. See	vork combined Not covered	Paid at 90% after \$200 copay; no deductible. Maximum of 120 days pe services and skilled nursir comb Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	deductible. r calendar year for rehab ng in- and out-of-network ined Not covered
		Prescription Drugs.			
Spinal Manipulations (T		T	
Paid at 100% after \$15 copay	\$15 copay. Deductible applies.	Paid at 80% after deductible.	Paid at 60% after deductible.	Paid at 100% after \$15 copay; no deductible.	Paid at 60% after deductible.
Self-referral to Kaiser Permanente designated providers. Must meet Kaiser Permanente protocol. Maximum of 10 visits per calendar year.		Maximum of 10 visits 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	Outpatient: \$15 copay	Outpatient: Paid at 80%			
100% after \$15 copay	Deductible applies	after deductible.	Outpatient: Paid at 60% after	Outpatient: Paid at 90% after deductible.	Outpatient: Paid at 60% after deductible.
		Tubal ligation: 100% no copay; no deductible.	deductible.	Tubal ligation: 100% no copay; no deductible.	
Temporomandibular J	oint Services				
Covered as any other service; copays/coinsurance depend on type and location of service provided. Tooth Injury/Oral Surg	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 maxim services in- and out-of-	depend on type and location of service provided. um for non-surgical	Covered as any other service; copays/coinsurance depend on type and location of service provided. \$5,000 lifetime maximum f and out-of-nety	depend on type and location of service provided. or non-surgical services in-
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%

Kaiser Per	manente*	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	
Vision Exam/Hard	lware					
Exam: Paid at	Exam: Paid at	Routine Exam: Paid	at 100% once	Routine Eye Exam: Paid at 100% once pe	r Routine Eye Exam: paid at 60%	
100% after \$15	100% after a \$15	per calenda	ar year	calendar year	after deductible	
copay. One exam	copay.	Hardware: Two lense	es per calendar			
every	One exam every	year;				
12 months.	12 months.	The lenses are betwe	een \$40 - \$130			
Hardware:	Hardware: Not	Single vision lens S	\$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 \$3	130 per lens	eyemedvision care.com/member/public/	discountPlans.emvc?execution=e1s2	
		Frames; \$30 every	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 obtaining		
	applies	for obtaining		precertification of high-tech radiology	/	
		precertification of				
		high-tech radiology				

^{*} a. Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.

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.