

City of Seattle—Retirees 65 and Over
2010 Benefit Highlights (updated 10/29/2009)

This is a brief summary of benefits. This is not a contract. For specific benefit information and exclusions, consult plan booklets.

	Original Medicare Part A & B	Aetna Medicare Open	Group Health Clear Care*	Secure Horizons Medicare Complete HMO
Plan Type	Original Medicare	Medicare Private Fee-For-Service	Medicare Advantage HMO	Medicare Advantage HMO
Annual Deductible	\$155	\$0	\$0	\$0
Out Of Pocket Cost Limitations				
Out of Pocket Maximum	Varies dependent on service	\$2,000 per calendar year	\$1,000 per calendar year; \$2,000 per family	\$2,000 per calendar year
Hospitalization				
Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility (see Mental Health and Alcohol/Drug Abuse Services)	First 60 days, all but \$1,100 covered; 61st to 90th day, all but \$275 a day; 91st to 150th day, all but \$550 a day (see booklet regarding one time use of up to 60 reserve days); beyond 150 days, \$0 is paid	\$250 copay per admission	\$100 copay per day up to a 3-day maximum, per admission	100% after \$200 copay, per admission
Skilled Nursing Facility Care				
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies	First 20 days, 100% of approved amount; additional 80 days, all but \$137.50 per day; beyond 100 days, \$0 is paid.	\$0 copay days 1-10, \$25 copay days 11-20, \$50 copay days 21-100, up to 100 days per benefit period	Covered up to 100 days per year, subject to Medicare guidelines and GHC approval. Must be in Medicare Certified facility.	\$0 copay days 1-20, \$50 copay days 21-100 up to 100 days per benefit period
Physician Network				
	May use any provider that accepts Medicare payments	Must only use providers that will accept the Aetna Private Fee-For-Service reimbursement	Must use only providers that contract with Group Health	Must use only providers that contract with Secure Horizons
Physician Services				
Physician care in hospital, home, office and most outpatient ancillary services	80% of approved amount subject to annual deductible	In-hospital visits covered at 100%. Outpatient visits covered in full after \$20 copay per visit	In-hospital visits covered at 100%. Outpatient visits covered in full after \$15 copay per visit	In-hospital visits covered at 100%. 100% after \$10 copay per PCP office visit; \$20 copy per Specialist office visit

Well Care				
Routine Physical Exams	“Welcome to Medicare” One time only, within first 6 months of enrolling in Part B; covers 80% of approved amount after deductible	One annual exam covered in full (includes Colorectal Cancer Screening and Bone Density Testing)	One annual exam covered in full	One annual exam covered in full
Routine Mammography	80% of approved amount	Covered in full one time per year	Covered in full one time per year	Covered in full
Routine Pap Smears	80% of approved amount	Covered in full one time per year	Covered in full	Covered in full
Other Wellness Services	Smoking cessation, cancer screening	Telephonic coaching, Personal Health Record, Informed 24-hour health phone line, Aetna Smart Source, Aetna Navigator, disease management	Personal Health Profile, 24-hour consulting nurse phone line, telephonic coaching, wellness web site, disease management	Senior Fitness Program, OptumHealth and Wellness advisory services, disease management
Diagnostic Lab & X-ray				
	80% of approved amount	Covered in full after \$20 copay	Covered in full	Covered in full
Mental Health and Alcohol/Drug Abuse Services				
Inpatient and Outpatient	Inpatient: Same deductible & co-payments as shown under Hospitalization Outpatient: 50% of approved amount for most outpatient mental health services, subject to annual deductible	Inpatient: 100% after \$250 copay per admission Outpatient: 100% after \$25 copay per individual visit	Inpatient: \$100 copay per day to 3-day maximum per member per admission; authorization required Outpatient: \$15 copay per visit, subject to Medicare guidelines, authorization required	Inpatient: 100% after \$200 copay per admission Outpatient: 100% after \$20 copay per individual visit; 100% after \$10 copay per Group office visit
				All referrals come through the Primary Care Physician (PCP)
Home Health Care				
Part-time or intermittent skilled care or home health aide services	100% of approved amount for most services	Covered in full	Covered in full for Medicare-certified skilled care through GHC Home Health Services, according to Medicare guidelines	Covered in full
Durable medical equipment and supplies	Varies depending on service	20% coinsurance	Covered in full according to Medicare guidelines	20% coinsurance
Emergency Care				
		Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$20 copay	Urgent Care: \$15 copay Emergency Room: \$50 copay Ambulance: \$150 copay	Urgent Care: \$50 copay Emergency Room: \$50 copay Ambulance: \$50 copay

Rehabilitation				
Speech, Physical And Occupational Therapy	80% for inpatient and outpatient services	Inpatient: 100% after \$250 copay per admission Outpatient: \$20 copay per visit	Inpatient: Subject to \$100 day copay up to a 3-day maximum per admission Outpatient: \$15 copay per visit	Inpatient: 100% after \$200 copay per admission Outpatient: \$25 copay per visit
Prescription Drugs				
	<p>Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected; for more info, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048</p>	<p>The following cost-sharing applies until the Initial Coverage Limit (ICL) of \$2,830 is reached: Retail: 31-day supply or one (1) Prescription Unit: \$5 copay for Generic, \$20 copay for Preferred Brand, \$40 copay for non-Preferred Brand Mail Order: 90-day supply through Aetna Rx Home Delivery: \$10 copay for Generic, after \$40 copay for Preferred Brand, \$80 copay for non-Preferred Brand</p> <p>After ICL is reached, only generics are covered until you have paid \$4,530 in true out-of-pocket expenses for drugs. After this, your cost share is the greater of \$2,540 or 5% for covered generics; the greater of \$6,300 or 5% for all other covered drugs.</p>	<p>Purchased at GHC facility: Generic - \$15 copay Brand - \$30 copay</p> <p>30-day supply for prescription or refill. Some exclusions apply. Copays do not apply toward out of pocket maximum.</p>	<p>The following cost-sharing applies until the Initial Coverage Limit (ICL) of \$2,700 is reached: Retail: 30-day supply or one (1) Prescription Unit: \$4 copay for Preferred Generic, \$28 copay for Preferred Brand, \$58 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drugs Mail Order: 90-day supply through SH mail service program. \$8 copay for Preferred Generic; \$74 copay for Preferred Brand, \$164 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drugs.</p> <p>After ICL is reached, there is no coverage until you have paid \$4,350 in true out-of-pocket expenses for drugs. After this, your cost share is the greater of \$2.40 or 5% for covered generics; the greater of \$6.00 or 5% for all other covered drugs.</p>

Vision Care				
Exams	Not covered	Covered in full one time per year	Covered in full once every 12 months after \$15 copay	Covered in full one time per year after \$20 copay
Eyeglass Lenses & Frames	Not covered, with the exception of one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens	Discounts where available	Standard lenses (including contact lenses) Single Vision - \$75 copay Bifocal - \$118 copay Trifocal - \$118 copay Lenticular - \$118 copay Frames covered up to \$100 once every 24 months	Not covered
Contact Lens Examination & Lenses	Not covered	Discounts where available	Cosmetic contact lenses - One pair \$135 copay	Not covered
Hearing Exams And Hearing Aids				
Exams	Routine exam not covered	Covered in full one time per year	Covered in full after \$15 copay per visit	Covered in full one time per year
Hearing Aids	Not covered	Discounts where available	Covered up to \$250 every 24 months; must be purchased through GHC	Covered up to \$500 every 3 years
Other Covered Services				
		Diabetic supplies covered at 100%		

Monthly Rates				
	Part B premium: \$110.50 per person month for income of \$85,000 or less (income of \$170,000 or less for joint filers). **	Washington State residents: Part B premium plus \$193.27 per person per month; Non-Washington State residents: Part B premium plus \$262.66 per person per month	Part B premium plus \$221.38 per person per month	Part B premium plus \$212.51 per person per month

*Group Health benefits provided are for members with Medicare A & B. Dependents without Medicare coverage have a different schedule of benefits.

*These rates apply to areas where Group Health does not have a Medicare Risk Contract. Medicare Advantage rates apply in all Western Washington Counties and Spokane County.

**Premium amounts for higher income levels at: http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_adp.php?p_faqid=2261