

## 2014 Medical Benefits Highlights – I.B.E.W. Local 77

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 [http://www.seattle.gov/personnel/resources/benefits\\_documents.asp](http://www.seattle.gov/personnel/resources/benefits_documents.asp).

Group Health Cooperative (GHC)	City of Seattle Traditional Plan		City of Seattle Preventive Plan	
	Preferred Provider	Non-Preferred Provider	Aetna In-Network	Out-of-Network
<b>Deductible</b> (per calendar year)				
No deductible	\$100 per person \$300 per family	\$150 per person \$450 per family	Does not apply	\$250 per person \$750 per family
<b>Annual Out of Pocket Maximum (OOP Max)</b> if applicable. Aetna Copays do not apply towards OOP Max.				
\$750 per person, \$1,500 per family	\$200 per person. Applies to 20% coinsurance	\$1,200 per person. Applies to 40% coinsurance *	\$500 per person \$1,000 per family	\$3,000 per person \$6,000 per family
<b>Hospital Copay</b>				
None	None	None	None	None
<b>Hospital Pre-admission Authorization</b>				
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care.	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	Member responsible for obtaining precertification of out-of-network care
<b>Choice of Providers</b>				
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on reasonable* charges. You pay the difference between R&C and billed charges.
<b>COVERED EXPENSES</b>				
<b>Acupuncture</b>				
Paid at 100% after \$5 copay. Self-referred up to 8 visits per condition per calendar year. Additional visits when approved by plan.	Paid at 80% Maximum of 12 visits per calendar year.	Paid at 60%	Paid at 100% after \$5 copay All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity	Paid at 70%
<b>Alcohol/Drug Abuse Treatment</b>				
Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay	Paid at 80% for inpatient and outpatient	Paid at 80% for inpatient and outpatient	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay	Inpatient: Paid at 70% Outpatient: Paid at 70%

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<b>Contraceptives</b>				
For contraceptive drugs and devices, see Prescription Drug benefit	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: see Prescription Drug benefit. Contraceptive devices and other prescription contraceptive products covered as medical benefit.	Oral contraceptive drugs: not covered. Contraceptive devices and other prescription contraceptive products covered as medical benefit.
<b>Durable Medical Equipment</b>				
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 100%	Paid at 70%
<b>Emergency Medical Care</b>				
➤ <b>Urgent Care Clinic</b>				
Paid at 100% after \$5 copay	Paid at 80%	Paid at 80%	Paid at 100% after \$35 copay	Paid at 70%
➤ <b>Emergency Room (copays waived if admitted)</b>				
GHC facility: Paid at 100% after \$50 copay (waived if admitted) Non-GHC facility: Paid at 100% after \$100 deductible (waived if admitted)	Paid at 80%.	Paid the same as in-network except if it's non-emergency, then it's 60%	Paid at 100% after \$50 copay (waived if admitted.)	Paid the same as in-network except if it's non-emergency, then it's 70% after \$50 copay. (waived if admitted).
➤ <b>Ambulance</b>				
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary. Non-emergency transport must be approved in advance.		Paid at 100% when medically necessary. Non-emergency transport must be approved in advance.	
<b>Hospital Inpatient</b>				
Paid at 100% .	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
<b>Hospital Outpatient</b>				
Paid at 100% after \$5 copay	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
<b>Hospice</b>				
Paid at 100% when authorized	Paid at 90%.		Paid at 100%	Not covered.
<b>Maternity Care (delivery &amp; related hospital)</b>				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

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<b>Maternity Care</b> (prenatal and postpartum)				
Paid at 100% after \$5 copay. Routine care not subject to outpatient services copay	Paid at 80%	Paid at 60%	Paid at 100% after \$5 copay	Paid at 70%
<b>Mental Health Care</b> (inpatient)				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
<b>Mental Health Care</b> (outpatient)				
Paid at 100% after \$5 copay per individual, family or couple session.	Paid at 80%	Paid at 60%	Paid at 100% after \$5 copay	Paid at 70%
<b>Physician Office Visit</b>				
\$5 copay	Paid at 80%	Paid at 60%	Paid at 100% after \$5 copay	Paid at 70%
<b>Prescription Drugs</b> (retail)				
For a 30-day supply: \$5 copay. Contraceptive drugs and devices are covered subject to the pharmacy copay.	For a 34-day supply or 100 unit supply (whichever is greater): \$8 copay for brand prescriptions. Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit. Non-formulary drugs not covered.	Not covered	For a 31-day supply: Generic: \$5 copay Preferred brand: \$10 copay Non-preferred drugs: \$25 copay Oral contraceptives are covered. Contraceptive devices and other prescription contraceptive products are covered under the medical plan benefit.	Not covered
<b>Prescription Drugs</b> (mail order)				
\$15 copay per 90-day supply	For a 90-day supply: \$16 copay. Non-formulary drugs are not covered	Not covered	For a 90-day supply: Generic: \$10 copay Preferred brand: \$20 copay Non-preferred drugs: \$50 copay	Not covered

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<b>Preventive Care</b>				
Paid at 100% for adult physical and well child exams, most immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening, pap smear exam, and mammogram.	Paid at 100% (deductible waived) for most preventive services. Mammograms paid at 80%. Sigmoidoscopies and colonoscopies paid at 50% after deductible.	Paid at 60% for mammograms, deductible waived. No other preventive services covered.	Paid at 100% for periodic check-ups, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services covered.
<b>Rehabilitation Services (inpatient)</b>				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maximum of 60 days per calendar year for occupational, speech, and physical therapy.			120 days per calendar year for skilled nursing and rehab services in-network and out-of-network combined.	
<b>Rehabilitation Services (outpatient)</b>				
Paid at 100% after \$5 copay	Paid at 80%		Paid at 100% after \$5 copay	Paid at 70%
Maximum of 60 visits per calendar year for occupational, speech, and physical therapy.	Coinsurance does not apply to out-of-pocket maximum. Maximum calendar year benefit of 30 visits for all services combined (physical/massage, speech, occupational and cardiac/pulmonary therapy).		Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Coinsurance does apply to the annual out-of-pocket maximum. Maximum of 20 visits per calendar year for each of the above listed benefits for in-network and out-of-network combined.	
<b>Skilled Nursing Facility</b>				
Paid at 100%; 60 day maximum per calendar year	Paid at 80%	Paid at 80%	Paid at 100%	Paid at 70%
	Maximum of 90 days per calendar year		Maximum of 120 days per calendar year for in-network and out-of-network combined	
<b>Smoking Cessation</b>				
Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No copay on all smoking cessation prescription drugs through mail-order.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered	Not covered	Not covered

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<b>Spinal Manipulations</b>				
Paid at 100% after \$5 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80% Maximum of 10 visits per calendar year	Paid at 80%	Paid at 100% after \$5 copay. Maximum of 20 visits per calendar year for in-network and out-of-network combined	Paid at 70%
<b>Sterilization Procedures</b>				
Vasectomy and tubal ligation covered subject to \$5 copay	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay.	Paid at 70%
<b>Tooth Injury (due to accident)</b>				
Not covered	Paid at 80%. Maximum \$600 per occurrence	Paid at 80%	Inpatient: Paid at 100% Outpatient: Paid at 100% after \$5 copay.	Paid at 70%
<b>Vision Care</b>				
Routine vision exam every 12 months. Paid at 100% after \$5 copay. Hardware not included. Additional coverage provided under VSP	Covered under VSP		Covered under VSP	
<b>X-ray and Lab Tests (Outpatient)</b>				
Paid at 100%	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%

\* Applies to Aetna -- Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

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