2016 Medical Plan Highlights - City of Seattle Retirees Age 65 and Over

This is a brief highlight of plan benefits. This is not a contract. For complete benefit information and exclusions, see plan booklets.

	Original Medicare Parts A & B ***2016 Information***	**Aetna*** **Medicare Plan (PPO)**	**Group Health*** **Medicare Advantage HMO (MAPD 3)**	**UnitedHealthCare*** **Medicare Advantage HMO****
Plan Type	Original Medicare	Medicare Advantage PPO	Medicare Advantage HMO	Medicare Advantage HMO
Annual Deductible	$166.00 (Part B)	$0	$0	$0
Out Of Pocket Cost Limitations				
Out of Pocket Maximum Limit per year	Varies dependent on service	$2,000 per individual	$2,500 per individual	$2,000 per individual
Hospitalization				
Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility	Days 1- 60, all but $1,288 covered; days 61- 90, all but $322 a day; days 91- 150 (reserve days), all but $644 a day; beyond 150 days, $0 paid	$250 copay per admission	Covered in full	$200 copay per admission
Skilled Nursing Facility Care				
Semiprivate room and board, skilled nursing and rehabilitation services/supplies	First 20 days, 100% of approved amount; additional 80 days, all but $161.00 per day; beyond 100 days, $0 paid.	$0 copay days 1-20, $75 copay days 21-100, up to 100 days per benefit period	Covered in full up to 100 days per benefit period	$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 use Preferred (in-network) providers or those Non-Preferred providers that will accept Aetna Medicare Advantage reimbursement	Must use providers that contract with Group Health	Must use providers that contract with UnitedHealthCare
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 $10 copay per visit	In-hospital visits covered at 100%. Outpatient visits covered in full after $10 copay per PCP visit; $20 copy per Specialist visit
Well Care				
Routine Physical Exams	One time only, within first 6 months of enrolling in Part B; covers 80% of approved amount after deductible	One exam every 12 months covered in full (includes Colorectal Cancer Screening and Bone Density Testing)	One annual exam covered in full	One annual exam covered in full

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Routine Mammography	80% of approved amount	Covered in full one time every 12 months	Covered in full	Covered in full
Routine Pap Smears	80% of approved amount	Covered in full one time every 24 months	Covered in full	Covered in full
Other Wellness Services	Smoking cessation, cancer screening	Telephonic coaching, Personal Health Record, Informed Health Line 24-hour nurse line, Aetna Smart Source, Aetna Navigator, Disease Management program	Personal Health Profile, 24-hour consulting nurse phone line, disease management, Smoking/ Tobacco Cessation, Silver Sneakers, MyGHC.org	Senior Silver Sneakers Fitness Program, disease management, 24 hour nurse line. Advanced illness.
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				
Inpatient and Outpatient	Inpatient: Same deductible & co-payments as shown under Hospitalization. Outpatient: 50% of approved amount for most services, subject to annual deductible	Inpatient: 100% after $250 copay per admission Outpatient: 100% after $20 copay per individual visit	Inpatient: 100%. 190-day lifetime maximum. Outpatient: $10 copay per visit,	Inpatient: 100% after $200 copay per admission; 190-day lifetime maximum. Outpatient: 100% after: $20 copay per individual visit; $10 copay per group visit. Referral required
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	Covered in full
Durable medical equipment/ supplies	Varies depending on service	20% coinsurance	Covered in full	20% coinsurance Diabetes Monitoring Supplies – Covered in full.
Emergency Medical Care				
		Urgent Care: $20 copay Emergency Room: $50 copay*** Ambulance: $20 copay	Urgent Care: $10 copay Emergency Room: $$75 copay*** Ambulance: $0 - $150 copay	Urgent Care: $35 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: 100% Outpatient: $10 copay per visit.	Inpatient: 100% after $200 copay per admission Outpatient: $25 copay per visit

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Prescription Drugs				
	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	**Initial Coverage Period**: Retiree copays for 1 month retail/3 months mail order: Preferred Generic: $5/$12.50 Non Pref Generic: $20/$50.00 Preferred Brand: $40/$100 Non-Pref Brand: $65/$162.50 Specialty: 25%/25% **Gap**: After retiree and plan spend $3,310 (in Initial Coverage Period) retiree pays: Preferred Generic*: $5/$10 Non Pref Gen*: $25/$50 Preferred Brand*: 45% Non-Pref Brand*: 45% Specialty*: 65% Gen, 45% Brand (“Brand” may include high cost generic: 65%) **Catastrophic:** Once $4,850 in true out-of-pocket costs is reached, retiree pays the greater of: $2.95 or 5% for Generic drugs; $7.40 or 5% for all other covered drugs	Retiree copays for 30-day supply purchased at GHC facility: Preferred Generic: $10 Non-Pref Generic: $20 Preferred Brand: $40 Non-Pref Brand: $90 Specialty: $150 Mail Order: 90-day supply through GHC mail order pharmacy (2x retail): Preferred Generic: $20 Non-Preferred Generic: $40 Preferred Brand: $80 Non-Preferred Brand: $180 Some exclusions apply. Copays do not apply toward out of pocket maximum.	**Initial Coverage Period**: Retiree copays for 1 month retail/3 months mail order: Preferred Generic: $4/$8 Preferred Brand: $28/$74 Non Pref Brand: $58/$164 Pref Specialty: 33%/33% **Gap**: After retiree and plan spend $3,310 (in Initial Coverage Period), retiree pays: Generic: 42% coinsurance Brand: 50% coinsurance **Catastrophic:** Once $4,850 in true out-of-pocket costs is reached, retiree pays the greater of: $2.95 or 5% for Generic drugs; $7.40 or 5% for all other covered drugs
Vision Care				
Exams	Not covered	Covered in full one time every 12 months	Covered in full one time per year	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	$150 hardware allowance every 12 months	Not covered
Contact Lens Exam & Lenses	Not covered	Discounts where available	Discounts available at gheyecare.org	Not covered

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Hearing Exams And Hearing Aids				
Exams	Routine exam not covered	Covered in full one time every12 months	Covered in full after $10 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 Services				
		Diabetic supplies covered at 100%		Voluntary one-on-one home visits with licensed clinician
Monthly Rates				
All rates are Per Person Per Month	Part B ***2016*** premium if you enroll in Part B for the first time in 2016: $121.80 for income of $85,000 or less (income of $170,000 or less for joint filers).**** Part B ***2015*** premium if you were enrolled in Part B in 2015: $104.90 for income of $85,000 or less (income of $170,000 or less for joint filers). ****	**Washington State residents:** Part B premium plus $289.18; **Non-Washington State residents:** Part B premium plus $310.00	Part B premium plus $286.30	Part B premium plus $362.45

*Benefits shown presume that members have Medicare Parts A & B coverage (dependents without Medicare coverage have a different schedule of benefits) and that services provided follow Medicare guidelines. “Year” refers to the calendar year, unless indicated otherwise. For Group Health and UnitedHealthcare plans, services must be obtained from approved network providers. For Aetna plans, services must be obtained from Preferred network providers or from Non-Preferred providers willing to accept the Aetna Medicare Advantage payment; there is no reimbursement for non-participating providers.

**The service area does not include Skagit and Whatcom counties.

***If admitted to the hospital, emergency room copay is waived.

****Premium amounts for higher income levels at: http://medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

Updated July 14, 2016