2017 Medical Benefits Highlights – Seattle Police Officers' Guild

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.

Group Health Cooperative (GHC)		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**
Deductible (per calendar year)					
No deductible	$200 per person $600 per family Deductible applies, except for prescriptions, preventive visits, ambulance, and DME.	$100 per person $300 per family	$150 per person $450 per family	Does not apply	$250 per person $750 per family
Annual Out of Pocket Maximum (OOP Max) includes medical coinsurance. Excludes the deductible and prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$750 per person $1,500 per family	$2,000 per person $6,000 per family	$400 per person. Applies to 20% coinsurance.	$1,600 per person. Applies to 40% coinsurance. *	$500 per person $1,000 per family	$3,000 per person* $6,000 per family*
Total Out of Pocket Maximum includes medical coinsurance and the deductible. Excludes prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$750 per person $1,500 per family	$2,000 per person $6,000 per family	$500 per person	$1750 per person	$500 per person $1,000 per family	$3,250 per person $6,750 per family
Hospital Copay					
None	None, deductible applies.	None	None	None	None
Hospital Pre-admission Authorization					
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
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers. Members may self-refer to most GHC specialists.		Aetna contracted provider members. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted provider member. No primary care physician selection required. No referrals required.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.

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COVERED EXPENSES					
Acupuncture					
Paid at 100%. 8 visits per condition per year self-referred. Additional visits when approved by plan.	Paid at 100% after $20 copay. 8 visits per condition per year self-referred. Additional visits when approved by plan. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
		Maximum of 12 visits per calendar year for in- and out-of-network combined		All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity	
Alcohol/Drug Abuse Treatment					
Inpatient: paid at 100% Outpatient: paid at 100%	Inpatient: Paid at 100% , deductible applies Outpatient: $20 copay, deductible applies	Paid at 80%	Paid at 80%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Inpatient: Paid at 70% Outpatient: Paid at 70%
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
		See Prescription Drug benefit		See Prescription Drug benefit	
Durable Medical Equipment (DME)					
Paid at 80%	Paid at 80%	Paid at 80%		Paid at 100%	Paid at 70%
Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100%	Paid at 100% after $20 copay, deductible applies.	Paid at 100% after $35 copay	Paid at 60%	Paid at 100% after $35 copay	Paid at 70%
Emergency Room (copays waived if admitted)					
GHC facility: Paid at 100% after $25 copay (waived if admitted). Non-GHC facility: Paid at 100% after $75 copay (waived if admitted.)	GHC facility: Paid at 100% after $75 copay (waived if admitted). Non-GHC facility: Paid at 100% after $125 copay (waived if admitted.). Deductible applies.	Paid at 80%	Paid at 80% Non-emergency, paid at 60%	Paid at 100% after $50 copay	Paid at 100% after $50 copay. Non-emergency paid 70% after $50 co-pay.
Ambulance					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	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 by Aetna.		Paid at 100% when medically necessary. Non-emergency transport must be approved in advance by Aetna.	
Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000

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		In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.		In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	
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Home Health Care					
Paid at 100% when authorized. No visit limit	Paid at 100% when authorized. No visit limit	Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.		Paid at 100% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined.	Paid at 70%
Hospital Inpatient					
Covered in ful.	Paid at 100%, deductible applies	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Hospital Outpatient					
Covered in full	Paid at 100% after $20 copay, deductible applies	Paid at 80% after deductible	Paid at 60% after deductible	Paid at 100%	Paid at 70%
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 90%		Paid at 100%	Not covered
Maternity Care (delivery & related hospital)					
Paid at 100%	Paid at 100%, deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Maternity Care (prenatal and postpartum)					
Paid at 100%	Paid at 100% after $20 copay. deductible applies. Routine care not subject to outpatient services copay	Paid at 80%	Paid at 60%	Paid 100% after $5 copay	Paid at 70%
Mental Health Care (inpatient)					
Covered in full.	Covered in full, deductible applies	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
Mental Health Care (outpatient)					
Paid at 100%	Paid at 100% after $20 copay, deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Physician Office Visit					
Paid at 100%	Paid at 100% after $20 copay, deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%

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Prescription Drugs (mail order)					
Mailing service available, subject to a $9 copay per 90-day supply. Contraceptive drugs and devices are covered subject to the pharmacy copay	Mailing service available, Generic: $30 copay per 90-day supply. Brand: $60 copay per 60-day supply. Contraceptive drugs and devices are covered subject to the pharmacy copay	For 90-day supply: Generic: $10 copay Preferred Brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered	For 90-day supply: Generic: $10 copay Preferred Brand name: $20 copay Non-preferred drugs: $50 copay	Not Covered
Prescription Drugs (retail)					
For a 30 day supply: $3 copay. Contraceptive drugs and devices are subject to the pharmacy copay.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay.	For a 34-day supply: **Generic**: $5 copay Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units. Preferred brand-name: $10 copay. Non-preferred: $25 copay. Many contraceptive products are covered. IUD and Depo Provera are covered under the medical plan benefits. Pharmacy out-of-pocket maximum of $1,200 per individual or $3,600 per family	Not covered	For a 31-day supply: **Generic**: $5 copay **Preferred brand name:** $10 copay. Non-preferred drugs: $25 copay. Many contraceptive products are covered. IUD and Depo Provera are covered under the medical plan benefit. Pharmacy out-of-pocket maximum of $1,200 per individual or $3,600 per family	Not covered

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Preventive Care					
Paid at 100%. Covers adult physical and well child exam, most immunizations, digital rectal exam/prostate-specific antigen test, colorectal cancer screening, pap smear exam, and mammogram.	Paid at 100% after $20 copay. Covers adult physical and well child exams, most immunizations, digital rectal exam/prostate-specific antigen test, colorectal cancer screening, pap smear exam, and mammogram.	Paid at 80% for mammograms. Other preventive services not covered.	Paid at 60% for mammograms. Other preventive services not covered.	Paid at 100% for routine physical exams, well child care, immunizations, well woman care and mammograms.	Paid at 70% for well woman care and mammograms. No other preventive services are covered.
Rehabilitation Services (inpatient)					
Paid at 100%	Paid at 100% Deductible applies	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70% after $200 copay
Maximum of 60 days per calendar year for occupational, speech, and physical therapy.	Maximum of 60 days per calendar year for occupational, speech, and physical therapy.			Maximum 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined	
Rehabilitation Services (outpatient)					
Paid at 100%	Paid at 100% after $20 copay, deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $5 copay	Paid at 70%
Maximum of 60 visits per calendar year for occupational, speech, and physical therapy	Maximum of 60 visits per calendar year for occupational, speech, and physical therapy	Coinsurance does not apply to the annual out-of-pocket maximum. Maximum calendar year benefit of 35 visits for physical/massage, speech, occupational and cardiac/pulmonary therapy for in-network and out-of-network combined.		Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 20 visits for each of the above listed benefits per calendar year for in-network and out-of-network combined.	
Skilled Nursing Facility					
Paid at 100%. 60 day maximum per calendar year.	Paid at 100%; 60 day maximum per calendar year, deductible applies.	Paid at 80%	Paid at 60%	Paid at 100%	Paid at 70%
		Maximum of 90 days per calendar year for in- and out-of-network combined.		Maximum of 120 days per calendar year for in- and out-of-network combined	

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Smoking Cessation					
Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No co-pay for all smoking cessation prescription drugs through mail-order.	Paid at 100% for individual/group sessions through Quit For Life. Nicotine replacement therapy included in Prescription Drugs benefit. No copay for 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
Spinal Manipulations					
Paid at 100% Self-referral to GHC designated providers.	Paid at 100% after $20 copay, deductible applies. Self-referral to GHC designated providers.	Paid at 80%		Paid at 100% after $5 copay	Paid at 70%
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 visits per calendar year for in-network and out-of-network combined.	
Sterilization Procedures					
Covered in full	$20 copay, deductible applies	Paid at 80%	Paid at 60%	Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%
Tooth Injury (due to accident)					
Not covered	Not covered	Paid at 80% $600 maximum per occurrence		Inpatient: Paid at 100% Outpatient: Paid at 100% after $5 copay.	Paid at 70%

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Vision Exam/Hardware					
Vision exam every 12 months: Covered in full Additional coverage provided under VSP	Vision exam every 12 months: Paid at 100% after $20 copay Hardware: not covered Additional coverage provided under VSP	Covered under VSP		Covered under VSP	
X-ray and Lab Tests (Outpatient)					
Paid at 100%	Paid at 100%, deductible applies	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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