

# Medical Benefits Highlights – I.B.E.W. Local 77 Choice Plans (New) (Effective July 1, 2014)

The purpose of this document is to help you make decisions; it is not a contract.

Group Health Cooperative (GHC)* Standard Plan	City of Seattle Traditional Plan*		City of Seattle Preventive Plan*	
	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Deductible</b> (per calendar year)				
No Deductible	\$400 per person \$1,200 per family  Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	\$1,000 per person \$3,000 per family  Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	\$100 per person \$300 per family  Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	\$450 per person \$1,350 per family  Deductible applies to most services, except as noted. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.
<b>Annual Out of Pocket Maximum (OOP Max)</b>				
Combined maximum for medical services and prescription drugs \$2,400 per person; \$4,800 per family	\$1,600 per person \$4,800 per family Medical services only	\$4,400 per person** \$13,000 per family* Medical services only	\$2,500 per person \$5,000 per family	\$3,800 per person* \$7,600 per family*
<b>Hospital Copay</b>				
\$200 per admission	\$200 copay per admission	\$200 copay per admission	\$200 copay per admission	\$200 copay per admission
<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.	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.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel*** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Aetna contracted providers. No primary care physician selection or referrals required. Aexcel** specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.

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
<b>COVERED EXPENSES</b>					
<b>Acupuncture</b>					
\$15 copay for up to 8 visits per condition per year self-referred. Additional visits when approved by plan.		Paid at 80%  Maximum of 12 visits per calendar year in- and out-of-network combined.		Paid at 60%  Paid at 100% after \$15 copay All acupuncture services are subject to ongoing review and approval by Aetna for medical necessity.	
<b>Alcohol/Drug Abuse Treatment</b>					
Inpatient: Paid at 100% after \$200 copay per admission Outpatient: Paid at 100% after \$15 copay		Inpatient: Paid at 80% after \$200 copay Outpatient: Paid at 80%		Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%	
<b>Contraceptives</b>					
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. May be covered at 100% no deductible as required under health care reform		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit. May be covered at 100% no deductible as required under health care reform	
<b>Durable Medical Equipment</b>					
Paid at 80%		Paid at 80% Breast pump covered at 100% through DME provider		Paid at 60%  Paid at 90% Breast pump covered at 100% through DME provider	
<b>Emergency Medical Care</b>					
<b>➤ Urgent Care Clinic</b>					
Paid at 100% after \$15 copay		Paid at 80%		Paid at 60%  Paid at 100% after \$15 copay (no fee for preventive care)	
<b>➤ Emergency Room (copays waived if admitted)</b>					
Paid in full after \$100 copay		Paid at 80% after \$150 copay		Paid at 80% after \$150 copay. If non-emergency, paid at 60% after copay.	
<b>➤ Ambulance</b>					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%		Paid at 80% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	

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<b>Gender Reassignment Services</b>					
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.	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.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
<b>Hearing Aids (per ear, every 36 months)</b>					
Up to \$1,000		Up to \$1,000 In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Up to \$1,000	Up to \$1,000 In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Up to \$1,000
<b>Home Health Care</b>					
Paid at 100% when authorized. No visit limit.		Paid at 80% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%	Paid at 90% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 60%
<b>Hospital Inpatient</b>					
Paid at 100% after \$200 copay per admission		Paid at 80% after \$200 copay. Physician services paid at 70% if Aexcel** specialist not used in specialty areas.	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay. Physician services paid at 80% if Aexcel** specialist not used in specialty areas.	Paid at 60% after \$200 copay
<b>Hospital Outpatient</b>					
Paid at 100% after \$15 copay		Paid at 80% after deductible. Physician services paid at 70% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible	Paid at 90% after deductible. Physician services paid at 80% if Aexcel** specialist is not used in specialty areas.	Paid at 60% after satisfaction of deductible
<b>Hospice</b>					
Paid at 100% when authorized		Paid at 80%	Paid at 60%	Paid at 90%	Not covered
<b>Maternity Care (delivery &amp; related hospital)</b>					
Paid at 100% after \$200 copay per admission		Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay
<b>Maternity Care (prenatal and postpartum)</b>					
Paid at 100% after \$15 copay Routine care not subject to outpatient services copay.		Paid at 80%	Paid at 60%	Paid 100% after one \$15 copay	Paid at 60%
<b>Mental Health Care (inpatient)</b>					
Paid at 100% after \$200 copay		Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay

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<b>Mental Health Care (outpatient)</b>					
Paid at 100% after \$15 copay		Paid at 80% after deductible		Paid at 100% after \$15 copay	Paid at 60% after deductible
<b>Physician Office Visit</b>					
Paid at 100% after \$15 copay.		Paid at 80%	Paid at 60%	Paid at 100% after \$15 copay per visit (waived for preventive care)	Paid at 60%
<b>Prescription Drugs (retail)</b>					
For a 30 day supply: <b>Generic:</b> \$15 copay <b>Brand:</b> \$30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay.		For a 31-day supply: <b>Generic:</b> 30% coinsurance. Not covered <b>Brand:</b> 40% coinsurance The minimum coinsurance is \$10, or actual cost of the drug if less. Maximum is \$100 per drug. Coinsurance applies to the prescription \$1,200 out-of-pocket annual maximum per person, \$3,600 per family. 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. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan. Generic Oral contraceptives are covered at 100% benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.		For a 31-day supply: Not covered <b>Generic:</b> 30% coinsurance <b>Brand:</b> 40% coinsurance The minimum coinsurance is \$10, or actual cost of the drug if less. Maximum is \$100 per drug.	
<b>Prescription Drugs (mail order)</b>					
For a 90 day supply: <b>Generic:</b> \$45 copay <b>Brand:</b> \$90 copay Contraceptive drugs and devices are covered in full.  Smoking cessation prescription drugs not subject to pharmacy copay.		For a 90-day supply: Not Covered <b>Generic:</b> 30% coinsurance <b>Brand:</b> 40% coinsurance Minimum is \$20 or double the cost of the drug if less. The maximum is \$200 per drug.		For a 90-day supply: Not Covered <b>Generic:</b> 30% coinsurance <b>Brand:</b> 40% coinsurance Minimum is \$20 or double the cost of the drug if less. The maximum is \$200 per drug.	
<b>Prescription Drug Annual Out-of-Pocket Maximum</b>					
<b>Combined</b> maximum for medical services and prescription drugs \$2,000 per person \$4,000 per family		\$1,200 per person \$3,600 per family		\$1,200 per person \$3,600 per family	

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<b>Preventive Care</b>				
Paid at 100% Covers adult physical and well child exams and most immunizations and preventive services.	Paid at 100%. Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening	Mammograms paid at 60%	Paid at 100% (copay waived) Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 60% for well woman care and mammograms No other preventive services covered
<b>Rehabilitation Services (inpatient)</b>				
Paid at 100% after \$200 copay per admission	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay Maximum of 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined	Paid at 60% after \$200 copay
<b>Rehabilitation Services (outpatient)</b>				
Paid at 100% after \$15 copay Maximum of 60 visits per calendar year for occupational, speech and physical therapy.	Paid at 80% Includes medically necessary physical/massage, speech, and occupational therapy for non-chronic conditions. Coinsurance does not apply to OOP Max. Coverage of services subject to Aetna's review for medical necessity at any time	Paid at 60%	Paid at 100% after \$15 copay Includes medically necessary physical/massage, speech, occupational and cardiac/pulmonary therapy for non-chronic conditions. Coverage of services subject to Aetna's review for medical necessity at any time	Paid at 60%
<b>Skilled Nursing Facility</b>				
Paid at 100%. 60 day maximum per calendar year.	Paid at 80% after \$200 copay Maximum of 90 days per calendar year for in- and out-of-network combined	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay Maximum of 120 days per calendar year for rehab services and skilled nursing in- and out-of-network combined	Paid at 60% after \$200 copay
<b>Smoking Cessation</b>				
Paid at 100% for individual or group sessions Nicotine replacement therapy included in Prescription Drug benefit.	Lifetime maximum of one 90-day supply of aids or drugs. Coinsurance 10% generic, 20% brand. See Prescription Drugs.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
<b>Spinal Manipulations</b>				
Paid at 100% after \$15 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 for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after \$15 copay Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60%

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	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Sterilization Procedures</b>				
Inpatient: Paid at 100% after \$200 copay Outpatient: Paid at 100% after \$15 copay Women's sterilization procedures covered in full	Inpatient: Paid at 80% after \$200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after \$200 copay Outpatient: Paid at 90%	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%
<b>Temporomandibular Joint Services</b>				
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 maximum for non-surgical services in- and out-of-network combined..	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 maximum for non-surgical services in- and out-of-network combined	Covered as any other service; copays/coinsurance depend on type and location of service provided.
<b>Tooth Injury (due to accident)</b>				
Not covered	Inpatient: Paid at 80% after \$200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%	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%
<b>Vision Exam/Hardware</b>				
Exam: Paid at 100% after \$15 copay. One exam every 12 months. Hardware: Not covered.	Covered under Vision Service Plan.		Covered under Vision Service Plan.	
<b>X-ray and Lab Tests</b>				
100%	Paid at 80% Provider responsible for obtaining precertification of high tech radiology	Paid at 60%	Paid at 90% Provider responsible for obtaining precertification of high tech radiology	Paid at 60%

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

\*\* 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.

\*\*\* Applies to Aetna – Aexcel network, a specialty network of doctors in 13 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the 13 specialty areas (coinsurance applies to in-network, out-of-pocket maximum). Call 1-877-292-2480 for more information about the Aexcel network.

**Plan details are in your medical plan booklet at [seattle.gov/personnel/benefits/health/medical.asp](http://seattle.gov/personnel/benefits/health/medical.asp). This document is not a contract.**