

2011 Benefit Highlights - City of Seattle Retirees Age 65 and Over (updated 11/18/2010)

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

	Original Medicare Parts A & B <i>2011 Information</i>	Aetna *	Aetna*	Group Health*	Secure Horizons*
		Medicare PPO 2011 (RX Group O6)	Medicare PPO (RX Group B6)	Clear Care	MedicareComplete HMO**
Plan Type	Original Medicare	Medicare Advantage PPO	Medicare Advantage PPO	Medicare Advantage HMO	Medicare Advantage HMO
Annual Deductible	\$162.00 (Part B)	\$0	\$0	\$0	\$0
Out Of Pocket Cost Limitations					
Out of Pocket Maximum Limit per year	Varies dependent on service	\$2,000 in Preferred Provider costs; \$10,000 in Preferred and Non-Preferred provider costs per individual	\$2,000 in Preferred provider costs; \$10,000 in Preferred and Non-Preferred provider costs	\$1,000 per individual; \$2,000 per family	\$2,000 per individual
Hospitalization					
Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility	(Part A) Days 1- 60, all but \$1,162 covered; days 61- 90, all but \$283 a day; days 91- 150 (reserve days), all but \$566 a day; beyond 150 days, \$0 paid	\$250 copay per admission	\$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/supplies	(Part A) First 20 days, 100% of approved amount; additional 80 days, all but \$141.50 per day; beyond 100 days, \$0 paid.	\$0 copay days 1-10, \$25 copay days 11-20, \$50 copay days 21-100, up to 100 days per benefit period	\$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 GHC approval.	\$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 that accept Aetna Medicare Advantage reimbursement (Non-Preferred providers)	Must use Preferred (in- network) providers or those that accept Aetna Medicare Advantage reimbursement (Non-Preferred providers)	Must use providers that contract with Group Health	Must use 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 \$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%. Outpatient visits covered in full after \$10 copay per PCP visit; \$20 copy per Specialist visit

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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 annual exam covered in full (includes Colorectal Cancer Screening and Bone Density Testing)	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 one time per year	Covered in full one time per year
Routine Pap Smears	80% of approved amount	Covered in full one time per year	Covered in full one time per year	Covered in full one time per year	Covered in full one time per year
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	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 Silver Sneakers Fitness Program, OptumHealth and Wellness advisory services, disease management, nurse line, Health Allies discount.
Diagnostic Lab & X-ray					
	80% of approved amount	Covered in full after \$20 copay	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 \$25 copay per individual visit	Inpatient: 100% after \$250 copay per admission Outpatient: 100% after \$25 copay per individual visit	Inpatient: 100% after \$100 copay per day up to a 3-day maximum per admission; authorization required Outpatient: \$15 copay per visit, authorization required	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 through GHC Home Health Services	Covered in full
Durable medical equipment/ supplies	Varies depending on service	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance

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		Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$20 copay	Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$20 copay	Urgent Care: \$15 copay Emergency Room: \$50 copay Ambulance: \$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% after \$250 copay per admission Outpatient: \$20 copay per visit	Inpatient: 100% after \$100/day copay up to a 3- day maximum per admission Outpatient: \$15 copay per visit; up to 60 visits per year	Inpatient: 100% after \$200 copay per admission Outpatient: \$25 copay per visit
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: Generic: \$5/\$10 Preferred Brand: \$20/\$40 Non-Pref Brand: \$40/\$80 Gap: After retiree spends \$2,840 (in Initial Coverage Period), retiree pays: Generic \$5/\$10 Preferred Brand*: 100% Non-Pref Brand*: 100% * same percentage for retail and mail order Catastrophic: Once \$4,550 in true out-of-pocket costs is reached, retiree pays the greater of: \$2.50 or 5% for Generics; \$6.30 or 5% for all other covered drugs	Initial Coverage Period: Retiree copays for 1 month retail/3 months mail order: Preferred Generic: \$4/\$12 Non Pref Generic: \$25/\$60 Preferred Brand: \$30/\$75 Non-Pref Brand: \$65/\$180 Specialty: 25%/25% Gap: After retiree spends \$2,840 (in Initial Coverage Period), retiree pays: Preferred Generic*: 93% Non Pref Gen*: 93% Preferred Brand*: 100% Non-Pref Brand*: 100% Specialty*: 93% Gen, 100% Brand	Retiree copays for 30-day supply purchased at GHC facility: Generic: \$15 copay Brand: - \$30 copay Some exclusions apply. Copays do not apply toward out of pocket maximum. Mail Order: 90-day supply through GHC mail order pharmacy. Generic: \$45 copay Brand: \$90 copay (Initial Coverage Period, Gap and Catastrophic do not apply.)	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 Speciality: 33%/33% Gap: After retiree spends \$2,840 (in Initial Coverage Period), retiree pays 100% Catastrophic: Once \$4,550 in true out-of-pocket costs is reached, retiree pays the greater of: \$2.50 or 5% for Generic drugs; \$6.30 or 5% for all other covered drugs

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Vision Care					
Exams	Not covered	Covered in full one time per year	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
Eye-glass 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	Discounts where available	Standard lenses (including contacts): \$75 copay for Single Vision; \$118 copay for Bifocal, Trifocal, Lenticular. Frames: up to \$100 once every 24 months	Not covered
Contact Lens Exam & Lenses	Not covered	Discounts where available	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 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	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%	Diabetic supplies covered at 100%		
Monthly Rates					
All rates are Per Person Per Month	Part B premium: \$115.40 for income of \$85,000 or less (income of \$170,000 or less for joint filers). ***	Washington State residents: Part B premium plus \$219.05; Non-Washington State residents: Part B premium plus \$284.06	Washington State residents: Part B premium plus \$156.01; Non-Washington State residents: Part B premium plus \$221.02	Part B premium plus \$168.02 ****	Part B premium plus \$238.01

*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 Secure Horizons 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.

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

****These rates apply in all Western Washington Counties and Spokane County.