

## 2009 Summary of Medical Benefits

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.

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>Deductible</b> (per calendar year)					
Does not apply	\$200 per person \$600 per family Except as noted, deductible applies to all services except prescriptions, preventive care visits, ambulance service, eye exams, and durable medical equipment.	\$400 per person \$1,200 per family Except as noted, deductible applies to most services. 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	\$100 per person \$300 per family Except as noted, deductible applies to most services. 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
<b>Annual Out of Pocket (OOP) Maximum*</b> (excluding deductible if applicable) Aetna Copays do not apply towards OOP					
\$2,000 per person \$4,000 per family	\$2,000 per person \$6,000 per family	\$1,000 per person \$3,000 per family applies to 20% coinsurance. Most costs paid at 100% after out-of-pocket maximum is paid	\$2,000 per person \$6,000 per family. applies to 40% coinsurance Most costs paid at 100% of recognized charge after out of pocket maximum is paid	\$2,000 per person \$4,000 per family Most costs paid at 100% after out-of-pocket maximum is paid	\$3,000 per person \$6,000 per family Most costs paid at 100% of recognized charge after out-of-pocket maximum is paid.
<b>Maximum Lifetime Benefits Payable</b>					
Combined \$2,000,000 lifetime maximum for Standard and Deductible plans		Combined \$2,000,000 lifetime maximum for Traditional and Preventive plans (in and out-of-network)			
<b>Inpatient Copay</b>					
\$200 per admission	Deductible applies.	\$200 copay per admission.	\$200 copay per admission.	\$200 copay per admission.	\$200 copay per admission.
<b>Inpatient Pre-admission Authorization</b>					
Except for maternity or emergency admissions, must be authorized by GHC	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		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
<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.	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.  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.	Any Aetna contracted provider member. No primary care physician selection required. No 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.

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>COVERED EXPENSES</b>					
<b>Acupuncture</b>					
Paid at 100% after \$15 copay Eight visits per condition per year self-referred. Additional visits with PCP referral.	\$15 copay. Eight visits per condition per year self-referred. Additional visits with PCP referral. Deductible applies.	Paid at 80%  Maximum of 12 visits per calendar year for in-network and out-of-network combined. Maximum does not include acupuncture treatment for chemical dependency.	Paid at 60%	Paid at 100% after \$15 copay	Paid at 60%
<b>Ambulance Service</b>					
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.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
<b>Bariatric Surgery</b>					
Limited coverage for morbidly obese adults. Surgery preauthorization requirements.	Limited coverage for morbidly obese adults. Surgery preauthorization requirements.	Limited coverage for morbidly obese adults. Surgery preauthorization requirements.	Not covered.	Limited coverage for morbidly obese adults. Surgery preauthorization requirements.	Not covered.
<b>Chemical Dependency Treatment (alcohol/drug addiction)</b>					
Inpatient: Paid at 100% after \$200 copay Outpatient: Paid at 100% after \$15 copay	Paid at 100%  Outpatient: Paid at 100% after \$15 co-pay.	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	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%
Combined benefit maximum \$14,500 per 24 month period for inpatient & outpatient services	Combined benefit maximum \$14,500 per 24 month period for inpatient & outpatient services	Combined benefit maximum of \$14,500 per 24 month period for in and out-of-network services		Combined benefit maximum \$14,500 per 24 month period for in-and out-of-network services	
<b>Complex Imaging Services</b>					
Paid at 100%	Paid at 100%, deductible applies.	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%
<b>Contraceptives</b>					
Contraceptive drugs and devices see Prescription Drug benefit.	Contraceptive drugs and devices see Prescription Drug benefit.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.
<b>Durable Medical Equipment</b>					
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%
<b>Emergency Room Services</b>					
GHC facility: Paid at 100% after \$100 copay (waived if admitted) Non-GHC facility: Paid at 100% after \$150 copay (waived if admitted)	GHC facility: \$100 copay. (waived if admitted) Non-GHC facility: \$125 copay (waived if admitted) Deductibles apply	Paid at 80% after \$150 copay waived if admitted	Paid the same as in network, except if it's non-emergency use, then 60% after \$150 copay (waived if admitted).	Paid at 90% after \$150 copay waived if admitted	Paid the same as in network, except if it's non-emergency use, then 60% after \$150 copay (waived if admitted).



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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Hearing Aids</b>					
Up to \$1,000 of coverage per ear every 36 months		Up to \$1,000 of coverage per ear every 36 months		Up to \$1,000 of coverage per ear every 36 months	
<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-network and out-of-network combined.		Paid at 90%  Paid at 60%  Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	
<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 is 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 is not used in specialty areas	
<b>Hospital Outpatient</b>					
Paid at 100% after \$15 copay for most visits		\$15 copay for most visits. Deductible applies.  Paid at 80% after satisfaction of 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 satisfaction of deductible.  Physician services paid at 80% if Aexcel specialist is not used in specialty areas	
<b>Hospice</b>					
Paid at 100% when authorized		Paid at 100% when authorized		Paid at 80%  Paid at 60%  Paid at 90%  Not covered.  Lifetime maximum of 6 months or \$10,000, whichever is greater. 14-day inpatient limit. 120-hour outpatient limit. Maximum of 6 months for inpatient and outpatient combined. Additional six months available if authorized	
<b>Maternity Care (delivery &amp; related hospital)</b>					
Paid at 100% after \$200 copay		Deductible applies.		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		\$15 copay. Deductible applies.		Paid at 80%  Paid at 60%  First pre-natal visit paid at 100% after \$15 copay. All other charges paid as part of the negotiated fee for entire pregnancy.  Paid at 60%	

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Mental Health Care (inpatient)</b>					
Paid at 100% after \$200 copay	Deductible applies.	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>Mental Health Care (outpatient)</b>					
Paid at 100% after a \$15 copay per individual, family or couple session or \$7.50 copay per group therapy visit. Copays apply to the out-of-pocket maximum	\$15 copay per individual, family or couple session. Copays apply to the out-of-pocket maximum. Deductible applies.	Paid at 80%  Coinsurance does not apply to the annual out-of-pocket maximum		Paid at 100% after \$15 copay.	Paid at 60% after deductible Coinsurance applies to the annual out-of-pocket maximum.
<b>Neurodevelopmental Therapy (for children under age 7)</b>					
Covered under Rehabilitation benefit.	Covered under Rehabilitation benefit.	Outpatient: Paid at 80%.  Maximum of \$5,000 per calendar year. Coinsurance does not apply to the out-of-pocket maximum.	Outpatient: Paid at 60%  .	Outpatient: Paid at 100% after \$15 copay.  Maximum of \$5,000 per calendar year for in-network and out-of-network combined.	Outpatient: Paid at 60% Coinsurance applies to the annual out-of-pocket maximum.
<b>Physician Office Visit</b>					
Paid at 100% after \$15 copay for most visits	\$15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after \$15 copay per visit (copay waived for preventive care visits)	Paid at 60%

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Prescription Drugs (retail)</b>					
<p>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.</p> <p>Copays do not apply to the annual out-of-pocket maximum.</p>	<p>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.</p> <p>Copays do not apply to the annual out-of-pocket maximum.</p>	<p>For a 34-day supply:  <b>Generic:</b> 30% coinsurance. Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units.  <b>Brand:</b> 40% coinsurance            The minimum coinsurance is \$10, or actual cost of the drug if less. The maximum is \$100 per drug.</p> <p>Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit.</p> <p>Coinsurance applies to the prescription \$1,200 out-of-pocket annual maximum per person, \$3,600 per family.</p> <p>Prescription Allowance on all non-sedating antihistamines and Proton Pump Inhibitors City pays \$20 per month, and plan participant pays remaining. (Some over the counter medications are included)</p> <p>\$5 copay for diabetic drugs and supplies for Diabetes Management Program enrollees.</p>	Not covered	<p>For a 31-day supply:  <b>Generic:</b> 30% coinsurance  <b>Brand:</b> 40% coinsurance            The minimum coinsurance is \$10, or actual cost of the drug if less. The maximum is \$100 per drug.</p> <p>Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit.</p> <p>Coinsurance applies to the prescription \$1,200 out-of-pocket annual maximum per person, \$3,600 per family.</p> <p>Prescription Allowance on all non-sedating antihistamines and Proton Pump Inhibitors. City pays \$20 per month, and plan participant pays remaining (Some over the counter medications included)</p> <p>\$5 copay for diabetic drugs and supplies for Diabetes Management Program enrollees.</p>	Not covered

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<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 subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90 day supply: <b>Generic:</b> \$30 copay <b>Brand:</b> \$60 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: <b>Generic:</b> 30% coinsurance <b>Brand:</b> 40% coinsurance  <b>The minimum coinsurance is \$20 or double the cost of the drug if less. The maximum is \$200 per drug.</b>	Not Covered	For a 90-day supply: <b>Generic:</b> 30% coinsurance <b>Brand:</b> 40% coinsurance  <b>The minimum coinsurance is \$20 or double the cost of the drug if less. The maximum is \$200 per drug.</b>	Not Covered
<b>Preventive Care</b>					
Paid at 100% after \$15 copay for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% after \$15 copay for preventive care visits, most immunizations, hearing exams, eye exams and mammograms. . Hearing exams are subject to deductible	Mammograms paid at 80%.  No other preventive services are covered.	Mammograms paid at 60%	Paid at 100% (copay waived) for routine physical exams, well child care, immunizations, well woman care and mammograms.	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	Deductible applies.	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay
Maximum of 60 days per calendar year (combined with other therapy benefits)	Maximum of 60 days per calendar year (combined with other therapy benefits)	Maximum of \$50,000 per condition for in-network and out-of-network combined.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	
<b>Rehabilitation Services (outpatient)</b>					
Paid at 100% after \$15 copay	\$15 copay	Paid at 80%	Paid at 60%	Paid at 100% after \$15 copay	Paid at 60%
Maximum of 60 visits per calendar year (combined with other therapy benefits)	Maximum of 60 visits per calendar year (combined with other therapy benefits). Deductible applies.	Coinsurance does not apply to the annual out-of-pocket maximum. Benefit includes physical/massage, speech, and occupational therapy. Maximum calendar year benefit of \$2,000 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.	
<b>Skilled Nursing Facility</b>					
Paid at 100%; 60 day maximum per calendar year.	60 day maximum per calendar year. Deductible applies.	Paid at 80% after \$200 copay	Paid at 60% after \$200 copay	Paid at 90% after \$200 copay	Paid at 60% after \$200 copay
		Maximum of 90 days per calendar year for in-network and out-of-network combined.		Maximum of 120 days per calendar year for in-network and out-of-network combined.	

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Smoking Cessation</b>					
Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit. Smoking cessation prescription drugs not subject to pharmacy copay.	Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit, Smoking cessation prescription drugs not subject to pharmacy copay	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs, retail.	Not covered.	Smoking cessation prescription drugs covered subject to 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.	\$15 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year. Deductible applies.	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%
<b>Sterilization Procedures</b>					
Outpatient: Paid at 100% after \$15 copay	Outpatient: \$15 copay. Deductible applies.	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 Surgery: Paid at 90%	Inpatient: Paid at 60% after \$200 copay Outpatient Surgery: Paid at 60%
<b>Temporomandibular Joint (TMJ) Services</b>					
Inpatient: Paid at 100% after \$200 copay per admission	Inpatient: Deductible applies.	Not covered		Not covered	
Outpatient: Paid at 100% after \$15 copay Maximum benefit of \$1,000 per calendar year/\$5,000 lifetime for inpatient and outpatient combined.	Outpatient: \$15 copay. Deductible applies. Maximum benefit of \$1,000 per calendar year/\$5,000 lifetime for inpatient and outpatient combined.				
<b>Tooth Injury due to accident</b>					
Not covered	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% after satisfaction of deductible.	Inpatient: Paid at 60% after \$200 copay Outpatient: Paid at 60%
		Services of dentist or denturist covered based on recognized charges* up to 12 months from injury date to a maximum of \$600 per occurrence. Physician and hospital benefits provided if inpatient care needed.		Services of dentist or denturist covered based on recognized charges* up to 12 months from injury date. Physician and hospital benefits provided if inpatient care needed.	

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Standard Plan	Deductible Plan	Aetna In-Network	Out-of-Network	Aetna In-Network	Out-of-Network
<b>Travel Outside of Country</b>					
Emergency: Paid at 100% after \$150 deductible Waived if admitted. Non-emergency: Not covered. Member must notify GHC within 24 hours of inpatient admission.	Emergency: Paid at 100% after \$125 deductible. Waived if admitted. Non-emergency: Not covered Member must notify GHC within 24 hours of inpatient admission	Not applicable	Paid at 80% after applicable office, emergency room or hospital copay for an emergency. Paid at 60% after applicable copay for non-emergency.	Not applicable	Paid at 100% after applicable office, emergency room or hospital copay. Paid at 60% after applicable copay for non-emergency.
<b>Urgent Care</b>					
Paid at 100% after \$15 copay for most visits	\$15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after \$15 copay per visit (copay waived for preventive care visits)	Paid at 60%
<b>Vision Hardware</b>					
Exam: Paid at 100% after \$15 copay at GHC. Also covered under VSP. Hardware: Covered under VSP.	Exam: Paid at 100% after \$15 copay at GHC. Also covered under VSP. Hardware: Covered under VSP.	Covered under Vision Service Plan		Covered under Vision Service Plan	
<b>Wellness Tools</b>					
On line health profile to determine health risks. Health report and recommendations based on profile. Unlimited lifestyle coaching.  Group Health Medical Records: All claims are included in the member's permanent record. Health profile data is integrated into the electronic medical record.	On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching.  Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A		On line health profile to determine health risks. Health report and recommendations based on profile. No lifestyle coaching.  Personal Health Record: Medical information is automatically populated based on claims data submitted. Targeted messages, alerts, and reminders via each individual's record.	N/A
<b>X-ray and Lab Tests</b>					
Paid at 100%	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90%. (Covered at 100% when associated with a routine physical exam)	Paid at 60%

\* 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 the 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). **Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract.**