2009 Summary of Medical Benefits - Most Retirees Under Age 65

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

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)					
Does not apply	$200 per person $600 per family Deductible applies except for prescriptions, preventive visits, ambulance, and durable medical equipment, except as noted.	$400 per person $1,200 per family	$1,000 per person $3,000 per family	$100 per person $300 per family	$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.		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.	
Annual Out of Pocket Maximum (OOP Max) Excludes deductible, if applicable. Aetna Copays do not apply towards OOP Max.					
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,000 per person $3,000 per family	$2,000 per person* $6,000 per family*	$2,000 per person $4,000 per family	$3,000 per person* $6,000 per family*
Maximum Lifetime Benefits Payable					
Combined $2,000,000 lifetime maximum for Standard and Deductible plans		Combined $2,000,000 lifetime maximum in- and out-of-network for Traditional and Preventive plans			
Inpatient Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Inpatient 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		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
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 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.
COVERED EXPENSES					
Acupuncture					
$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral.	$15 copay for up to 8 visits per condition per year self-referred. Additional visits with PCP referral. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
		Maximum of 12 visits per calendar year for in- and out-of-network combined.			
Ambulance Service					
Paid at 80%.	Paid at 80%.	Paid at 80% when medically necessary		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance	
GHC-initiated non-emergency transfers are paid at 100%					
Bariatric Surgery					
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
Chemical Dependency Treatment (alcohol/drug addiction)					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 100% Outpatient: Paid at 100% after $15 co-pay. 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: Paid at 100% after $15 copay	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Combined benefit maximum of $14,500 per 24 month period for inpatient and outpatient services		Combined benefit maximum of $14,500 per 24 month period for in- and out-of-network services		Combined benefit maximum of $14,500 per 24 month period for in- and out-of-network services	
Contraceptives					

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For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera are covered as medical benefits. See Prescription Drug benefit.		IUDs and Depo Provera are covered as medical benefits. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80%	Paid at 60%	Paid at 90%	Paid at 60%
Emergency Room Services (copays waived if admitted)					
GHC facility: $100 copay Non-GHC facility: $150 copay	GHC facility: $100 copay Non-GHC facility: $125 copay Deductible applies	Paid at 80% after $150 copay	Paid at 80% after $150 copay. If non-emergency, paid at 60% after copay.	Paid at 90% after $150 copay	Paid at 90% after $150 copay. If non-emergency, paid at 60% after copay.
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
Home Health Care					
Paid at 100% when authorized. No visit limit.	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%
Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100%. Deductible applies.	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
Hospital Outpatient					
Paid at 100% after $15 copay for most visits	$15 copay for most visit. Deductible applies.	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
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit; 120-hour outpatient limit.	Paid at 60%	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)					
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
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid 100% after one $15 copay	Paid at 60%
Mental Health Care (inpatient)					
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
Mental Health Care (outpatient)					
Paid at 100% after $15 copay per individual, family or couple session, $7.50 copay per group. Copays apply to OOP Max.	$15 copay per individual, family or couple session. Copays apply to OOP Max. Deductible applies.	Paid at 80% Coinsurance does not apply to OOP Max		Paid at 100% after $15 copay	Paid at 60% after deductible. Coinsurance applies to OOP Max.
Neurodevelopmental Therapy (for children under age 7)					
See Rehabilitation Services	See Rehabilitation Services	Outpatient: Paid at 80%. Maximum of $5,000 per calendar year. Coinsurance does not apply to OOP Max.	Outpatient: Paid at 60%	Outpatient: Paid at 100% after $15 copay Maximum of $5,000 per calendar year for in- and out-of-network combined	Outpatient: Paid at 60% Coinsurance applies to OOP Max
Physician Office Visit					

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Paid at 100% after $15 copay for most visits	Paid at 100% after $15 copay for most visits. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay per visit (waived for preventive care)	Paid at 60%
Prescription Drugs (retail)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to OOP Max. Smoking cessation prescription drugs not subject to pharmacy copay.	For a 34-day supply: **Generic**: 30% coinsurance. **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. Maximum is $100 per drug.	Not covered
		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 diabetic drugs and supplies for those enrolled in Diabetes Management Program. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit.			
Prescription Drugs (mail order)					
For a 90 day supply: **Generic**: $45 copay **Brand:** $90 copay	For a 90 day supply: **Generic**: $30 copay **Brand:** $60 copay	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance Minimum is $20 or double the cost of the drug if less. The maximum is $200 per drug.	Not Covered
Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the OOP Max.					
Preventive Care					
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 subject to deductible.	Mammograms paid at 80%.	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
		No other preventive services are covered			
Rehabilitation Services (inpatient)					
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 $50,000 per condition for in- and out-of-network combined		Maximum of 120 days per calendar year for in- and out-of-network combined	
Rehabilitation Services (outpatient)					
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)		Includes physical/massage, speech, and occupational therapy. Maximum calendar year benefit of $2,000 for in- and out-of-network combined. Coinsurance does not apply to OOP Max.		Includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 20 visits for each therapy per calendar year for in- and out-of-network combined.	
Skilled Nursing Facility					
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- and out-of-network combined		Maximum of 120 days per calendar year for in- and out-of-network combined	
Smoking Cessation					
Paid at 100% for individual or group sessions	Paid at 100% for individual or group sessions	Lifetime maximum of one 90-day supply of aids or drugs. See Prescription Drugs, retail.	Not covered	Smoking cessation prescription drugs covered subject to coinsurance	Not covered
Nicotine replacement therapy included in Prescription Drug benefit					

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Spinal Manipulations					
Paid at 100% after $15 copay	$15 copay. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
Self-referral to GHC designated providers. Must meet GHC protocol. 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					
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: Paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Temporomandibular Joint (TMJ) Services					
Inpatient: Paid at 100% after $200 copay per admission Outpatient: $15 copay	Inpatient: Deductible applies. Outpatient: $15 copay. Deductible applies.	Not covered		Not covered	
Maximum benefit of $1,000 per calendar year and $5,000 lifetime for inpatient and outpatient combined.					
Tooth Injury due to accident					
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%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Travel Outside of Country					
Emergency: Paid at 100% after $150 deductible. Waived if admitted. Non-emergency: Not covered.	Emergency: Paid at 100% after $125 deductible. Waived if admitted. Deductible applies.	Not applicable	Paid at 80% after applicable copay for an emergency. For non-emergency, paid at 60% after applicable copay.	Not applicable	Paid at 100% after applicable copay for an emergency. For non-emergency, paid at 60% after applicable copay.
Member must notify GHC within 24 hours of inpatient admission.					
Urgent Care					
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%
Vision Hardware					
Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100%. Hardware: Two lenses per calendar year; $20-$40 per lens; frames: $30 every other year.		Not covered	
Wellness Tools					
On line health profile to determine health risks; health report and recommendations; lifestyle coaching; 24-hour consulting nurse; health profile data integrated into the electronic medical record		On line health profile to determine health risks; health report and recommendations; medical information is automatically populated into personal health record; targeted messages, alerts, and reminders			
X-ray and Lab Tests					
Paid at 100%	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90%	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 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).

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