

## City of Seattle—Retirees 65 and Over 2009 Benefit Summary

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

	<b>Original Medicare Part A &amp; B</b>	<b>Aetna Medicare Open</b>	<b>Group Health Clear Care*</b>	<b>Secure Horizons Medicare Complete HMO</b>
<b>Plan Type</b>	Original Medicare	Medicare Private Fee-For-Service	Medicare Advantage HMO	Medicare Advantage HMO
<b>Annual Deductible</b>	\$135	\$0	\$0	\$0
<b>Out Of Pocket Cost Limitations</b>				
Out of Pocket Maximum	Varies dependent on service	\$2,000 per calendar year	\$1,000 per calendar year; \$2,000 per family	\$2,000 per calendar year
<b>Hospitalization</b>				
Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility (see Mental Health and Alcohol/Drug Abuse Services)	First 60 days, all but \$1,068 covered; 61st to 90th day, all but \$267 a day; 91st to 150th day, all but \$534 a day (see booklet regarding one time use of up to 60 reserve days); beyond 150 days, \$0 is paid	\$250 copay per admission	\$100 copay per day up to a 3-day maximum, per admission	100% after \$200 copay, per admission
<b>Skilled Nursing Facility Care</b>				
Semiprivate room and board, skilled nursing and rehabilitation services and other services and supplies	First 20 days, 100% of approved amount; additional 80 days, all but \$133.50 per day; beyond 100 days, \$0 is paid.	\$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 Medicare guidelines and GHC approval. Must be in Medicare Certified facility.	\$0 copay days 1-20, \$50 copay days 21-100 up to 100 days per benefit period
<b>Physician Network</b>				
	May use any provider that accepts Medicare payments	Must only use providers that will accept the Aetna Private Fee-For-Service reimbursement	Must use only providers that contract with Group Health	Must use only providers that contract with Secure Horizons
<b>Physician Services</b>				
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 \$15 copay per visit	In-hospital visits covered at 100%. 100% after \$10 copay per PCP office visit; \$20 copay per Specialist office visit

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<b>Well Care</b>				
Routine Physical Exams	“Welcome to Medicare” 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 (when in accordance with GHC Well Adult & Well Child Schedule)	One annual exam covered in full
Routine Mammography	80% of approved amount	Covered in full one time per year	Covered in full	Covered in full
Pap Smears	80% of approved amount	Covered in full one time per year	Covered in full	Covered in full
Other Wellness Services	Smoking cessation, cancer screening	Telephonic coaching, health assessment tools, Informed 24-hour health phone line, Aetna Navigator, disease management	Personal Health Profile, 24-hour nurse consulting phone line, telephonic coaching, wellness web site, disease management	Senior Fitness Program, OptumHealth and Wellness advisory services, disease management
<b>Diagnostic Lab &amp; X-ray</b>				
	Covered in full	Covered in full after \$20 copay	Covered in full	Covered in full after \$10 copay
<b>Mental Health and Alcohol/Drug Abuse Services</b>				
Inpatient and Outpatient (inpatient care has a 190 day lifetime maximum)	Inpatient: Same deductible & co-payments as shown under Hospitalization Outpatient: 50% of approved amount for most outpatient mental health services, subject to annual deductible	Inpatient: 100% after \$250 copay per admission Outpatient: 100% after \$25 copay per individual visit	Inpatient: \$100 copay per day to 3-day maximum per member per admission; authorization required Outpatient: \$15 copay per visit, subject to Medicare guidelines, authorization required	Inpatient: 100% after \$200 copay per admission Outpatient: 100% after \$20 copay per individual visit; 100% after \$10 copay per Group office visit
				All referrals come through the Primary Care Physician (PCP)
<b>Home Health Care</b>				
Part-time or intermittent skilled care or home health aide services	100% of approved amount for most services	Covered in full	Covered in full for Medicare-certified skilled care through GHC Home Health Services, according to Medicare guidelines	Covered in full
Durable medical equipment and supplies	Varies depending on service	20% coinsurance	Covered in full according to Medicare guidelines	20% coinsurance

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<b>Emergency Care</b>				
		Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$20 copay	Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$150 copay	Urgent Care: \$50 copay Emergency Room: \$50 copay Ambulance: \$50 copay
<b>Rehabilitation</b>				
Speech, Physical And Occupational Therapy	80% for inpatient and outpatient services	Inpatient: 100% after \$250 copay per admission Outpatient: \$20 copay per visit	Inpatient: Subject to \$100 day copay up to a 3-day maximum per admission Outpatient: \$15 copay per visit	Inpatient: 100% after \$200 copay per admission Outpatient: \$25 copay per visit
<b>Prescription Drugs</b>				
	Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected; for more info, visit <a href="http://www.medicare.gov">www.medicare.gov</a> on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048	The following cost-sharing applies until the <b>Initial Coverage Limit (ICL)</b> of \$2,700 is reached: <b>Retail:</b> 31-day supply or one (1) Prescription Unit: 100% after \$5 copay for Generic, 100% after \$20 copay for Preferred Brand, 100% after \$40 copay for non-Preferred Brand <b>Mail Order:</b> 90-day supply through Aetna Rx Home Delivery: 100% after \$10 copay for Generic; 100% after \$40 copay for Preferred Brand, 100% after \$80 copay for non-Preferred Brand  After ICL is reached, only generics are covered until you have paid \$4,350 in true out-of-pocket expenses for drugs. After this, your cost share is the greater of \$2.40 or 5% for covered generics; the greater of \$6.00 or 5% for all other covered drugs.	Purchased at GHC facility:  Generic - \$15 copay Brand - \$30 copay  30-day supply for prescription or refill. Some exclusions apply. Copays do not apply toward out of pocket maximum	<b>Retail:</b> 100% after \$4 copay for Preferred Generic, 100% after \$28 copay for Preferred Brand, 100% after \$58 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug. 30-day supply or one (1) Prescription Unit <b>Mail Order:</b> 90-day supply through SH contracted mail service program. 100% after \$8 copay for Preferred Generic; 100% after \$74 copay for Preferred Brand, 100% after \$164 copay for non-Preferred Brand; 33% coinsurance for Preferred Specialty Drug

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<b>Vision Care</b>				
Exams	Not covered	Covered in full one time per year	Covered in full once every 24 months after \$15 copay	Covered in full one time per year after \$20 copay
Eyeglass 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	Standard lenses (including contact lenses) Single Vision - \$75 copay Bifocal - \$118 copay Trifocal - \$118 copay Lenticular - \$118 copay Frames covered up to \$100 once every 24 months	Not covered
Contact Lens Examination & Lenses	Not covered	Discounts where available	Cosmetic contact lenses - One pair \$135 copay	Not covered
<b>Hearing Exams And Hearing Aids</b>				
Exams	Routine exam not covered	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	Covered up to \$250 every 24 months; must be purchased through GHC	Covered up to \$500 every 3 years
<b>Other Covered Services</b>				
		Diabetic supplies covered at 100%		

\*Group Health benefits provided are for members with Medicare A & B. Dependents without Medicare coverage have a different schedule of benefits.

\*These rates apply to areas where Group Health does not have a Medicare Risk Contract. Medicare Advantage rates apply in all Western Washington Counties and Spokane County.

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You can receive additional Medicare information for 2009 by looking at: [www.medicare.gov](http://www.medicare.gov) on the web, or by calling 1-800-633-4227.