

## 2012 Medical Plan Highlights - City of Seattle Retirees Age 65 and Over

This is a brief highlight of plan 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**	Group Health**	United HealthCare**
		Medicare Plan (PPO)	Clear Care HMO Plan	Medicare Complete HMO***
<b>Plan Type</b>	Original Medicare	Medicare Advantage PPO	Medicare Advantage HMO	Medicare Advantage HMO
<b>Annual Deductible</b>	\$162.00 (Part B)	\$0	\$0	\$0
<b>Out Of Pocket Cost Limitations</b>				
Out of Pocket Maximum Limit per year	Varies dependent on service	\$2,000 per individual	\$2,500 per individual	\$2,000 per individual
<b>Hospitalization</b>				
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	Covered in full.	100% after \$200 copay, per admission
<b>Skilled Nursing Facility Care</b>				
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	Covered in full up to 100 days per benefit period.	\$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 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
<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 \$10 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

<b>Well Care</b>				
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	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
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
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	Personal Health Profile, 24-hour consulting nurse phone line, telephonic coaching, wellness web site, disease management, Silver Sneakers, Enhance Fitness,	Senior Silver Sneakers Fitness Program, disease management, 24 hour nurse line, Treatment Decision Support. Personal Health Management Program
<b>Diagnostic Lab &amp; X-ray</b>				
	80% of approved amount	Covered in full after \$20 copay	Covered in full	Covered in full
<b>Mental Health and Alcohol/Drug Abuse</b>				
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 \$20 copay per individual visit	Inpatient: 100%. Limited to 190 days per lifetime; authorization required Outpatient: \$10 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
<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	Covered in full
Durable medical equipment/ supplies	Varies depending on service	20% coinsurance	20% coinsurance	20% coinsurance
<b>Emergency Medical Care</b>				
		Urgent Care: \$20 copay Emergency Room: \$50 copay Ambulance: \$20 copay	Urgent Care: \$ \$10 copay Emergency Room: \$65 copay Ambulance: \$150 copay	Urgent Care: \$35 copay Emergency Room: \$50 copay Ambulance: \$50 copay

	<b>Original Medicare Parts A &amp; B 2011 Information*</b>	<b>Aetna** Medicare Plan (PPO)</b>	<b>Group Health** Clear Care HMO Plan</b>	<b>United HealthCare ** Medicare Complete HMO***</b>
<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: 100% after \$100/day copay up to a 3-day maximum per admission Outpatient: \$10 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	<p><b>Initial Coverage Period:</b> Retiree copays for 1 month retail/3 months mail order:</p> <p>Preferred Generic: \$5/\$12.50 Non Pref Generic: \$25/\$62.50 Preferred Brand: \$40/\$100 Non-Pref Brand: \$65/\$162.50 Specialty: 25%/25%</p> <p><b>Gap:</b> After retiree and plan spends \$2,930 (in Initial Coverage Period), retiree pays:</p> <p>Preferred Generic*: \$5/\$12.50 Non Pref Gen*: \$25/\$62.50 Preferred Brand*: 100% Non-Pref Brand*: 100% Specialty*: 86% Gen, 86% Brand</p> <p><b>Catastrophic:</b> Once \$4,700 in true out-of-pocket costs is reached, retiree pays the greater of: \$2.60 or 5% for Generic drugs; \$6.50 or 5% for all other covered drugs</p>	<p>Retiree copays for 30-day supply purchased at GHC facility:</p> <p>Generic: \$10 copay Brand: \$40 copay Nonformulary: 50%</p> <p>Some exclusions apply. Copays do not apply toward out of pocket maximum.</p> <p>Mail Order: 90-day supply through GHC mail order pharmacy. Generic: \$20 copay Brand: \$80 copay Nonformulary: 50%</p>	<p><b>Initial Coverage Period:</b> Retiree copays for 1 month retail/3 months mail order:</p> <p>Preferred Generic: \$4/\$8 Preferred Brand: \$28/\$74 Non Pref Brand: \$58/\$164 Pref Speciality: 33%/33%</p> <p><b>Gap:</b> After retiree and plan spends \$2,840 (in Initial Coverage Period), retiree pays 100%</p> <p><b>Catastrophic:</b> Once \$4,770 in true out-of-pocket costs is reached, retiree pays the greater of: \$2.60 or 5% for Generic drugs; \$6.50 or 5% for all other covered drugs</p>

	Original Medicare Parts A & B <i>2011 Information*</i>	Aetna**	Group Health**	United HealthCare **
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<b>Vision Care</b>				
Exams	Not covered	Covered in full one time per year	Covered in full once every 12 months after \$ \$10copay	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	\$100 hardware allowance every 24 months.	Not covered
Contact Lens Exam & Lenses	Not covered	Discounts where available	Discounts available at gheyecare.org	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 \$10 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 Services</b>				
		Diabetic supplies covered at 100%		
<b>Monthly Rates</b>				
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). ****	<b>Washington State residents:</b> Part B premium plus \$187.00; <b>Non-Washington State residents:</b> Part B premium plus \$257.98	Part B premium plus \$248.15	Part B premium plus \$261.81

\*Original Medicare Parts A & B information is not available for 2012; when available, updated comparison charts will be posted on the Retirement website.

\*\*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:

[https://questions.medicare.gov/app/answers/detail/a\\_id/2306/kw/2012%20Part%20B%20Premium%20Amounts%20for%20Persons](https://questions.medicare.gov/app/answers/detail/a_id/2306/kw/2012%20Part%20B%20Premium%20Amounts%20for%20Persons)