2017 Medical Benefits Highlights - Most City of Seattle Retirees Under Age 65

The purpose of this document is to help you make decisions. It is not a contract. Details are provided in your medical plan booklet at seattle.gov/personnel/benefits/health/medical.asp.

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)					
No Deductible	$200 per person $600 per family Deductible applies as noted except for prescriptions, preventive visits, ambulance, and durable medical equipment.	$400 per person $1,200 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.	$1,000 per person $3,000 per family	$100 per person $300 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.	$450 per person $1,350 per family
Annual Out of Pocket Maximum (OOP Max) includes medical coinsurance. Excludes the deductible and prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$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*
Total Out of Pocket Maximum includes medical coinsurance and the deductible. Excludes prescription drug copays/coinsurance.					
Includes medical copays		Excludes copays		Excludes copays	
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,400 per person $4,200 per family	$3,000 per person $9,000 per family	$2,100 per person $4,300 per family	$3,450 per person $7,350 per family
Hospital Copay					
$200 per admission	Deductible applies	$200 copay per admission	$200 copay per admission	$200 copay per admission	$200 copay per admission
Hospital 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. Member responsible for obtaining precertification of out-of-network care.		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission Member responsible for obtaining precertification of out-of-network care.	

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Choice of Providers					
All care and services provided at Group Health Facilities or network 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 medical diagnosis per calendar year. Additional visits when approved.	$15 copay for up to 8 visits per medical diagnosis per calendar year. Additional visits when approved. Deductible applies.	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
		Up to 12 visits per calendar year in- and out-of-network combined		Up to 20 visits per calendar year in- and out-of-network combined	
Alcohol/Drug Abuse Treatment					
Inpatient: Paid at 100% after $200 copay per admission	Inpatient: Paid at 100% after deductible	Inpatient: Paid at 80% after $200 copay	Inpatient: Paid at 60% after $200 copay	Inpatient: Paid at 90% after $200 copay	Inpatient: Paid at 60% after $200 copay
Outpatient: Paid at 100% after $15 copay	Outpatient: Paid at 100% after $15 co-pay Deductible applies	Outpatient: Paid at 80%	Outpatient: Paid at 60%	Outpatient: Paid at 100% after $15 copay	Outpatient: Paid at 60%
Contraceptives					
For contraceptive drugs and devices, see Prescription Drug benefit		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.		IUDs and Depo Provera covered as medical benefits. See Prescription Drug benefit.	
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80% Breast pump covered at 100% through DME provider	Paid at 60%	Paid at 90% Breast pump covered at 100% through DME provider	Paid at 60%
Emergency Medical Care					
➢ **Urgent Care Clinic**					
Paid at 100% after $15 copay	$15 copay Deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay (no fee for preventive care)	Paid at 60%

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➢ **Emergency Room (copays waived if admitted)**					
GHC facility: $100 copay Non-GHC facility: $150 copay	GHC facility: $100 copay Non-GHC facility: $150 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
➢ **Ambulance**					
Paid at 80%.	Paid at 80%.	Paid at 80% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Gender Reassignment Services					
Covered as any other service; copays/coinsurance depending on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.
Hearing Aids (per ear, every 36 months)					
Up to $1,000	Up to $1,000	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.	Up to $1,000	Up to $1,000 In-network coinsurance applies whether purchased in- or out-of-network. Deductible does not apply.
Home Health Care					
Paid at 100% when authorized. No visit limit	Paid at 100% when authorized. No visit limit	Paid at 80%	Paid at 60% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined	Paid at 90%	Paid at 60% Maximum benefit of 130 visits per calendar year for in- and out-of-network combined
Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible	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	$15 copay 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

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Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80%	Paid at 60%	Paid at 90%	Not covered
Maternity Care (delivery & related hospital)					
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
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay Routine care not subject to outpatient services copay.	$15 copay Deductible applies. Routine care not subject to outpatient services copay.	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	Paid at 100% after deductible	Paid at 80% after $200 copay In complex situations, such as hospitalization, residential treatment centers and partial hospitalization, review and coordination of care is required.	Paid at 60% after $200 copay	Paid at 90% after $200 copay Review and coordination of care in complex situations including residential treatment centers and partial hospitalization.	Paid at 60% after $200 copay
Mental Health Care (outpatient)					
Paid at 100% after $15 copay per individual, family or couple session.	$15 copay per individual, family or couple session. Deductible applies.	Paid at 80% after $200 copay in complex situations, such as psychological testing, neurological testing and intensive outpatient treatment, review and coordination of care is required.	Paid at 60% after $200 copay	Paid at 100% after $15 copay Additional focus on review and coordination of care in complex situations including psychological testing, neurological testing and intensive outpatient.	Paid at 60% after deductible
Physician Office Visit					
Paid at 100% after $15 copay.	Paid at 100% after $15 copay. Deductible applies	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay per visit (waived for preventive care)	Paid at 60%

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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. 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. Smoking cessation prescription drugs not subject to pharmacy copay.	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	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 generic diabetic drugs and supplies, $15 copay for brand. Many contraceptive products are covered. IUDs and Depo Provera covered under the medical plan benefit. Coinsurance for asthma, anti-high cholesterol, and tobacco cessation drugs 10% for generic and 20% for brand pharmacy.			
Prescription Drugs (mail order)					
For a 90 day supply: **Generic**: $45 copay **Brand:** $90 copay Contraceptive drugs and devices are covered subject to the pharmacy 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

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Preventive Care					
Paid at 100% after $15 copay	Paid at 100% after $15 copay	Mammograms paid at 80%. No other preventive services are covered	Mammograms paid at 60%	Paid at 100% (copay waived) Covers adult physical and well child exams, immunizations, digital rectal exams/prostate-specific antigen test, colorectal cancer screening.	Paid at 60% for well woman care and mammograms No other preventive services covered
Rehabilitation Services (inpatient)					
Paid at 100% after $200 copay per admission	Paid at 100% after deductible.	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 120 days per calendar year for skilled nursing and rehab services in- and out-of-network combined	
Rehabilitation Services (outpatient)					
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%
Maximum of 60 visits per calendar year (combined with other therapy benefits)		Twenty-five visits per calendar year for physical, massage and occupational therapy. Additional visits may be covered if deemed medically necessary. Coinsurance does not apply to OOP Max.		Twenty-five visits per calendar year for physical, massage and occupational therapy. Additional visits may be covered if deemed medically necessary.	
Skilled Nursing Facility					
Paid at 100%. 60 day maximum per calendar year.	60 day maximum per calendar year. Paid at 100% after deductible.	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 rehab services and skilled nursing 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. Coinsurance 10% generic, 20% brand. See Prescription Drugs.	Not covered	Smoking cessation prescription drugs covered subject to 10% generic, 20% brand drug coinsurance.	Not covered
Nicotine replacement therapy included in Prescription Drug benefit					

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Spinal Manipulations					
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. 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%
Sterilization Procedures					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 100% 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 Services					
Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided. $5,000 lifetime maximum for non-surgical services in- and out-of-network combined	Covered as any other service; copays/coinsurance depend on type and location of service provided.	Covered as any other service; copays/coinsurance depend on type and location of service provided. $5,000 lifetime maximum for non-surgical services in- and out-of-network combined	Covered as any other service; copays/coinsurance depend on type and location of service provided.
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%

Vision Exam/Hardware				
Exam: Paid at 100% after $15 copay. One exam every 12 months. Hardware: Not covered.	Exam: Paid at 100% after $15 copay. One exam every 12 months. Hardware: Not covered.	Routine Exam: Paid at 100% once per calendar year Hardware: Two lenses per calendar year; $20-$40 per lens; Frames; $30 every other year	Routine Eye Exam: Paid at 100% once per calendar year Hardware: Not covered. Discounts available through Portal.eyemedvisioncare.com/wps/portal/emweb	Routine Eye Exam: paid at 60% after deductible
X-ray and Lab Tests				
Paid at 100%	Paid at 100% Deductible applies	Paid at 80% Provider responsible for obtaining precertification of high tech radiology	Paid at 60%	Paid at 90% Provider responsible for obtaining precertification of high tech radiology Paid at 60%

* Coverage for any service is subject to the carrier's determination of medical necessity and adherence to their clinical policy guidelines.

** 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). Call 1-877-292-2480 for more information about the Aexcel network.

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