2021 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, see plan booklets.

	Original Medicare Parts A & B ***2020 Information***	**Aetna*** **Medicare Plan (PPO)**	**Kaiser Permanente*** **Medicare Advantage HMO Plan 3**	**Kaiser Permanente** **Medicare Advantage HMO Plan 4**	**UnitedHealthCare*** **Medicare Advantage HMO****
Plan Type	Original Medicare	Medicare Advantage PPO	Medicare Advantage HMO	Medicare Advantage HMO	Medicare Advantage HMO
Annual Deductible	$198.00 (Part B)	$0	$0	$0	$0
Out of Pocket Cost Limitations					
Out of Pocket Maximum Limit per year	Varies dependent on service	$2,000 per individual	$2,500 per individual	$2,500 per individual	$2,000 per individual
Hospitalization					
Semiprivate room and board, general nursing and other hospital services and supplies in a medical facility	Days 1- 60, all but $1,408 covered; days 61- 90, all but $352 a day; days 91-150 (reserve days), all but $704 a day; beyond 150 days, $0 paid	$250 copay per admission	Covered in full	$100 per admission	$200 copay per admission
Skilled Nursing Facility Care					
Semiprivate room and board, skilled nursing and rehabilitation services/supplies	First 20 days, 100% of approved amount; additional 80 days, all but $176.00 per day; beyond 100 days, $0 paid.	$0 copay days 1-20, $75 copay days 21-100, up to 100 days per benefit period	Covered in full 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
Physician Network					
	May use any provider that accepts Medicare payments	Must use Preferred (in-network) providers or those Non-Preferred providers that will accept Aetna Medicare Advantage reimbursement	Must use providers that contract with Kaiser Permanente	Must use providers that contract with Kaiser Permanente	Must use providers that contract with UnitedHealthCare
Physician Services					
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 $15 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

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Well Care					
Routine Physical Exams	One time only, within first 6 months of enrolling in Part B; covers 80% of approved amount after deductible	One exam every 12 months covered in full (includes Colorectal Cancer Screening and Bone Mass Measurement)	One annual exam covered in full	One annual exam covered in full	One annual exam covered in full
Routine Mammography	80% of approved amount	Covered in full one time every 12 months	Covered in full	Covered in full	Covered in full
Routine Pap Smears	80% of approved amount	Covered in full one time every 24 months	Covered in full	Covered in full	Covered in full
Other Wellness Services	Smoking cessation, cancer screening	Telephonic coaching, Personal Health Record, Informed Health Line 24-hour nurse line, Resources for Living, Aetna Navigator, Disease Management programs	Personal Health Profile, 24-hour consulting nurse phone line, disease management, Smoking/ Tobacco Cessation, Silver & Fit, KPWA Member Website, and Mobile App	Personal Health Profile, 24-hour consulting nurse phone line, disease management, Smoking/ Tobacco Cessation, Silver & Fit, KPWA Member Website, and Mobile App	Silver Sneakers Fitness Program, disease management, 24 hour nurse line. Advanced illness.
Diagnostic Lab & X-ray					
	80% of approved amount	Covered in full after $20 copay	Covered in full	Covered in full	Covered in full
Mental Health and Alcohol/Drug Abuse					
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%. Outpatient: $10 copay per visit	Inpatient: $100 per admission. Outpatient: $15 copay per visit	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
Home Health Care					
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	Covered in full
Durable medical equipment/ supplies	Varies depending on service	20% coinsurance	Covered in full	20% coinsurance	20% coinsurance Diabetes Monitoring Supplies – Covered in full.

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Emergency Medical Care					
		Urgent Care: $20 copay Emergency Room: $90 copay*** Ambulance: $20 copay	Urgent Care: $10 copay Emergency Room: $75 copay*** Ambulance: $0 - $150 copay	Urgent Care: $15 copay Emergency Room: $75 copay*** Ambulance: $0 - $150 copay	Urgent Care: $35 copay Emergency Room: $50 copay*** Ambulance: $50 copay
Rehabilitation					
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% Outpatient: $10 copay per visit.	Inpatient: $100 copay Outpatient: $15 copay per visit.	Inpatient: 100% after $200 copay per admission Outpatient: $25 copay per visit

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Prescription Drugs					
	Retiree selects a prescription Part D plan from a vendor, and pays a premium for the plan selected; for more info, visit www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048	**Initial Coverage Period**: Retiree copays for 1 month retail/3 months mail order: Preferred Generic: $5/$12.50 Generic: $20/$50 Preferred Brand: $40/$100 Non-Preferred Drug: $65/$162.50 Specialty: 25% (1 month supply only) **Gap**: After retiree and plan spend $4,130 (in Initial Coverage Period) retiree pays: Preferred Generic: $5/$12.50 Generic: $20/$50 Preferred Brand: 25%/25% Non-Preferred Drug: 25%/25% Specialty: 25% (1 month supply only) **Catastrophic:** Once $6,550 in true out-of-pocket costs is reached, retiree pays the greater of: $3.70 or 5% for Generic drugs; $9.20 or 5% for all other covered drugs	Retiree copays for 30-day supply purchased at a KPWA facility: Preferred Generic: $3 Generic: $7 Preferred Brand: $40 Non-preferred Brand: $90 Specialty: $150 Mail Order: 90-day supply through KPWA mail order pharmacy (2x retail). **Gap**: After retiree and plan spend $4,130 (in Initial Coverage Period) retiree pays the same copays listed above during the initial coverage stage. **Catastrophic:** Once $6,550 in true out-of-pocket costs is reached, retiree pays the greater of: Generic: $3.70 or 5% Brand Name: $9.20 or 5%	Retiree copays for 30-day supply purchased at a KPWA facility: Preferred Generic: $3 Generic: $7 Preferred Brand: $40 Nonpreferred Brand: $90 Specialty: $150 Mail Order: 90-day supply through KPWA mail order pharmacy (2x retail). **Gap**: After retiree and plan spend $4,130 (in Initial Coverage Period) retiree pays the same copays listed above during the initial coverage stage. **Catastrophic:** Once $6,550 in true out-of-pocket costs is reached, retiree pays the greater of: Generic: $3.70 or 5% Brand Name: $9.20 or 5%	**Initial Coverage Period**: Retiree copays for 1 month retail/3 months mail order: Preferred Generic: $4/$8 Preferred Brand: $28/$74 Non Pref Brand: $58/$164 Pref Specialty: 33%/33% **Gap**: After retiree and plan spend $4,130 (in Initial Coverage Period), retiree pays: Generic: 37% coinsurance Brand: 25% coinsurance **Catastrophic:** Once $6,550 in true out-of-pocket costs is reached, retiree pays the greater of: $3.70 or 5% for Generic drugs; $9.20 or 5% for all other covered drugs

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Vision Care					
Exams	Not covered	Covered in full one time every 12 months	$10 copay one time per year	$15 copay one time per year	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	$250 hardware allowance every 12 months	$150 hardware allowance every 12 months	Not covered
Contact Lens Exam & Lenses	Not covered	Discounts where available		Not covered.	Not covered
Hearing Exams And Hearing Aids					
Exams	Routine exam not covered	Covered in full one time every 12 months	Exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam: Not covered	Exam to diagnose and treat hearing and balance issues: **$15** copay Routine hearing exam: Not covered	Covered in full one time per year
Hearing Aids	Not covered	Discounts where available	Covered up to $1,000 every 24 months; must be purchased through Kaiser	Covered up to $750 every calendar year; must be purchased through Kaiser	Covered up to $500 every 3 years
Other Services					
		Diabetic supplies covered at 100%			Voluntary one-on-one home visits with licensed clinician
Monthly Rates					
All rates are Per Person Per Month	Part B ***2020*** premium is $144.60 per month if your yearly 2018 income was $87,000 or less (income of $174,000 or less for joint filers).**** Part B ***2020*** premium is $202.40 per month if your yearly 2018 income was above $87,000 or up to $109,000 (income above $174,000 up to $218,000 for joint filers).****	**Washington State residents:** Part B premium plus $297.84; **Non-Washington State residents:** Part B premium plus $317.34	Part B premium plus $427.70	Part B premium plus $408.12	Part B premium plus $373.45

*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 Kaiser Permanente and UnitedHealthcare 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.

***If admitted to the hospital, emergency room copay is waived.

****Premium amounts for higher income levels at: http://medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html

Updated October 8, 2020