

**Aetna Medicare<sup>SM</sup> Plan (PPO)**  
**2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

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**AETNA LIFE INSURANCE COMPANY**

**Contract Holder Name: The City Of Seattle**  
**Contract Holder Group Agreement Effective Date: January 1, 2012**  
**Contract Holder Number: 430517**

This Medical Benefits Chart is part of the *Evidence of Coverage* for Aetna Medicare Plan (PPO). When the *Evidence of Coverage* refers to the attachment for information on health care benefits covered under our plan, it is referring to this Medical Benefits Chart. (See Chapter 4, Medical Benefits Chart (what is covered and what you pay).

<b>Annual Deductible</b>	
The deductible is the amount you must pay for medical services before our plan begins to pay its share	\$0

<b>Annual Maximum Out-of-Pocket limit</b>	
The maximum out-of-pocket limit applies to all covered Medicare benefits including deductible	
<b>Maximum out-of-pocket amount for <u>in-network</u> medical services</b>	\$2,000
<b>Maximum out-of-pocket amount for <u>both in-network and out-of- network</u> medical services</b>	\$2,000

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Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<b>Inpatient Care</b>	
<p><b>Inpatient hospital care*</b></p> <p>There is no limit to the number of days covered by the plan for each hospital stay. Covered services include:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If our plan provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</li> </ul>	<p>For Medicare-covered hospital stays:</p> <p>\$250 per admission</p> <p>Transplant coverage provided through the Institutes of Excellence<sup>TM</sup> Network</p>

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<p>Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood.† All other components of blood are covered beginning with the first pint used.</p> <ul style="list-style-type: none"> <li>• Physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>†Your former employer/union/trust may offer additional coverage if listed in “Additional Benefits” at the end of this Medical Benefit Chart</p> <p>*Prior authorization rules apply.</p>	
<p><b>Inpatient mental health care*</b></p> <ul style="list-style-type: none"> <li>• Covered services include mental health care services that require a hospital stay.</li> </ul> <p>*Prior authorization rules apply.</p>	<p>\$250 per admission</p>

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<p><b>Skilled nursing facility (SNF) care*</b></p> <p>(For a definition of “skilled nursing facility care,” see the chapter titled “Definitions of Important Words” in the <i>Evidence of Coverage</i>. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p><b>100</b> days covered for each benefit period. No prior hospital stay is required. Covered services include:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood.† All other components of blood are covered beginning with the first pint used</li> <li>• Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician services</li> </ul> <p>†Your former employer/union/trust may offer additional coverage if listed in “Additional Benefits” at the end of this Medical Benefit Chart</p> <p>*Prior authorization rules apply.</p>	<p>\$0 per day 1 - 10 days</p> <p>\$25 per day 11 - 20 days</p> <p>\$50 per day 21 - 100 days</p>

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<p><b>Inpatient services covered during a non-covered inpatient stay</b></p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Physician services</li> <li>• Diagnostic tests (like lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices</li> <li>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p>You are covered for these services according to Medicare guidelines.</p> <p>You pay applicable copayments or coinsurance listed in this Benefits Chart for covered services received.</p>
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<p><b>Home health agency care*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than</li> </ul>	<p>\$0 per visit, plus applicable DME cost sharing for any covered supplies</p>
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<ul style="list-style-type: none"> <li>• 8 hours per day and 35 hours per week.)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul> <p>*Prior authorization rules apply.</p>	
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<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"> <li>• You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing</li> <li>• --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for</li> </ul>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.</p>
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<p>the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</p> <p><b>Note:</b> If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit on an as needed basis. Palliative care consultation is also available.</p>	<p>Consultation services included in <b>Inpatient hospital care; Physician services</b> cost sharing applies for outpatient consultations.</p>

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Outpatient Services	
<p><b>Physician services, including doctor’s office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Medically-necessary medical or surgical services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment</li> <li>• Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> <li>• Second opinion by another network provider prior to surgery</li> <li>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</li> </ul>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> <li>• the tests/services/supplies you receive</li> <li>• the provider of the tests/services/supplies</li> <li>• the setting where the tests/services/supplies are performed.</li> </ul> <p>If you receive multiple services in one visit, you generally pay only the cost sharing of the highest-cost service.</p> <p>\$20 per visit to a primary care doctor</p> <p>\$20 per visit to a specialist</p> <p>\$20 per visit for each Medicare covered dental service</p>

<p><b>Outpatient hospital services</b></p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient</li> </ul>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> <li>• the tests/services/supplies you receive</li> <li>• the provider of the tests/services/supplies</li> </ul>
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<ul style="list-style-type: none"> <li>• clinic, including same-day surgery</li> <li>• Laboratory tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain screenings and preventive services</li> <li>• Certain drugs and biologicals that you can't give yourself</li> </ul> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<ul style="list-style-type: none"> <li>• the setting where the tests/services/supplies are performed.</li> </ul> <p>If you receive multiple services in one visit, you generally pay only the cost sharing of the highest-cost service.</p> <p>Please refer to the following sections in this benefits chart for more information:</p> <ul style="list-style-type: none"> <li>• <b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b></li> <li>• <b>Outpatient diagnostic tests and therapeutic services and supplies</b></li> </ul>
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• We cover only manual manipulation of the spine to correct subluxation</li> </ul>	<p>\$15 per visit</p>

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<p><b>Podiatry services</b> Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> </ul>	\$20 per visit
<p><b>Outpatient mental health care</b></p> <p>Covered services include: Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	\$20 per visit
<p><b>Partial hospitalization services</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	\$20 per visit
<p><b>Outpatient substance abuse services</b></p>	\$20 per visit/day
<p><b>Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers</b></p> <p><b>Note:</b> If you are having surgery in a hospital, you should check with your provider about whether you will be an</p>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> <li>- the tests/services/supplies you receive</li> <li>- the provider of the tests/services/supplies</li> <li>- the setting where the</li> </ul>

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<p>inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p> <p>*Prior authorization rules apply for certain services; contact Member Services for information.</p>	<p>tests/services/supplies are performed.</p> <p>If you receive multiple services in one visit, you generally pay only the cost sharing of the highest-cost service.</p> <p>\$0 per visit to an outpatient hospital facility</p> <p>\$0 per visit to an ambulatory surgical center</p>
<p><b>Ambulance services*</b></p> <ul style="list-style-type: none"> <li>Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.</li> <li>Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.</li> <li>Round trip transport applies for each Medicare-covered ambulance transport to a physician office or</li> </ul>	<p>\$20 per trip (one way)</p>

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<p>dialysis visit.</p> <p>*Prior authorization rules apply for air ambulance transfers and non-emergency transportation by ground ambulance or medical van.</p>	
<p><b>Emergency care</b>            Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.            A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>This coverage is available world-wide.</p>	<p>\$50 per visit</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p>
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.</p> <p>This coverage is available world-wide.</p>	<p>\$20 per visit</p>
<p><b>Outpatient rehabilitation services</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various</p>	<p>\$20 per visit</p>

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outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	
<p><b>Cardiac rehabilitation services</b></p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	\$20 per visit
<p><b>Pulmonary rehabilitation services</b></p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	\$20 per visit
<p><b>Durable medical equipment and related supplies*</b></p> <p>(For a definition of “durable medical equipment,” see the chapter titled “Definition of Important Words” in your <i>Evidence of Coverage</i>.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>*Prior authorization rules apply for certain services; contact Member Services for information.</p>	20% of the cost for each Medicare covered item

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<p><b>Prosthetic devices and related supplies*</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>*Prior authorization rules apply for certain services; please contact Member Services for information.</p>	<p>20% of the cost for each Medicare covered item</p>
<p><b>Diabetes self-management training, diabetic services and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> </ul>	<p>\$0 for Medicare-covered services</p>

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<p><b>Outpatient diagnostic tests and therapeutic services and supplies*</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Complex imaging such as: MRI, MRA, PET scan</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Laboratory tests</li> <li>• Blood. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood.<sup>†</sup> Coverage of storage and administration begins with the first pint of blood that you need.</li> <li>• Other outpatient diagnostic tests</li> </ul> <p>†Your former employer/union/trust may offer additional coverage if listed in “Additional Benefits” at the end of this Medical Benefit Chart</p> <p>*Prior authorization rules apply for certain services; please contact Member Services for information.</p>	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> <li>- the tests/services/supplies you receive</li> <li>- the provider of the tests/services/supplies</li> <li>- the setting where the tests/services/supplies are performed.</li> </ul> <p>If you receive multiple services in one visit, you generally pay only the cost sharing of the highest-cost service.</p> <p>\$20 per visit to a primary care doctor</p> <p>\$20 per visit to a specialist</p> <p>\$20 for each X-ray</p> <p>\$20 for each complex imaging</p> <p>\$20 per test for each lab service</p> <p>\$20 per visit per test for each diagnostic procedure or test</p> <p>\$20 per visit for each therapeutic radiology service</p> <p>20% for each Medicare-covered medical supply item</p> <p>20% of the cost for each Medicare-covered medical supply item</p>

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	\$0 copay for blood after the first 3 unreplaced pints†
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once every 12 months.</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> <li>• Our plan covers one routine eye exam every 12 months</li> </ul>	<p>\$20 per visit to diagnose and treat diseases and conditions of the eye</p> <p>\$0 copay for one glaucoma screening every 12 months</p> <p>\$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery</p> <p>\$0 copay every 12 months</p>

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<p><b>Preventive Services</b> For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.</p>	
<p><b>Abdominal aortic aneurysm screening</b>  A one-time screening ultrasound per lifetime for people at risk.</p>	\$0 copay
<p><b>Bone mass measurement</b>  For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 12 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	\$0 copay
<p><b>Colorectal cancer screening</b>  For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening</li> </ul>	\$0 copay

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sigmoidoscopy	
<p><b>HIV screening</b> For people who ask for an HIV screening test or who are at increased risk for HIV infection, or for women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Three screening exams every 12 months</li> </ul>	\$0 copay
<p><b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once a year in the fall or winter</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> <li>• We also cover some vaccines under our Part D prescription drug benefit.</li> </ul>	<p>\$0 copay No referral needed Office visit copay may apply</p>
<p><b>Breast cancer screening (mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	\$0 copay
<b>Cervical and vaginal cancer screening</b>	

**Aetna Medicare<sup>SM</sup> Plan (PPO)  
2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<p>Covered services include:</p> <ul style="list-style-type: none"> <li>For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months</li> </ul>	<p>\$0 copay \$0 copay for up to one additional Pap smear and pelvic exam every 12 months</p>
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>Digital rectal exam</li> <li>Prostate Specific Antigen (PSA) test</li> </ul>	<p>\$0 copay</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months)</p>	<p>\$0 copay</p>
<p><b>“Welcome to Medicare” physical exam</b></p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p><b>Important:</b> You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” physical exam.</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.</p>

**Aetna Medicare<sup>SM</sup> Plan (PPO)**  
**2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<p><b>Annual wellness visit</b>            You can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p><b>Diabetes screening</b>            We cover this screening (includes fasting glucose tests) twice every 12 months if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p>	<p>\$0 copay</p>
<p><b>Medical nutrition therapy</b>            This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor.            We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and three hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another calendar year.</p>	<p>\$0 copay</p>
<p><b>Smoking and tobacco use cessation (counseling to stop smoking)</b>            If you use tobacco, but do not have signs or symptoms of</p>	<p>If you haven’t been diagnosed with an illness caused or</p>

**Aetna Medicare<sup>SM</sup> Plan (PPO)  
2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<p>tobacco-related disease: we cover eight face-to-face counseling sessions within a 12-month period.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover eight face-to-face counseling sessions within a 12-month period.</p>	<p>complicated by tobacco use: \$0 copay</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: \$0 copay</p>
<p><b>Other Services</b></p>	
<p><b>Services to treat kidney disease and conditions*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the <i>Evidence of Coverage</i>)</li> <li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul>	<p>\$20 per visit for kidney disease education services received from your PCP</p> <p>\$20 per visit for kidney disease education services received from other providers</p> <p>\$20 per visit for in- and out-of-area outpatient dialysis</p> <p>Inpatient dialysis – refer to inpatient hospital care at the beginning of this benefits chart</p> <p>20% of the cost for each Medicare covered item</p> <p>\$0 per visit for Medicare-covered home support services</p>

**Aetna Medicare<sup>SM</sup> Plan (PPO)  
2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p> <p>* Prior authorization rules apply for certain services; contact Member Services for information.</p>	
<p><b>Medicare Part B prescription drugs</b></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency disease</li> <li>• Enhanced drug benefit if listed in “Additional</li> </ul>	<p>\$0 per prescription or refill</p>

**Aetna Medicare<sup>SM</sup> Plan (PPO)**  
**2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<p>Benefits” section below</p> <p>Refer to your plan’s Evidence of Coverage: Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in the Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance) section of this chart.</p>	
<p><b>Additional Benefits</b></p>	
<p><b>Hearing services</b></p> <ul style="list-style-type: none"> <li>• Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</li> <li>• Our plan covers one routine hearing exam every 12 months</li> </ul>	<p>\$20 per exam for basic hearing evaluations</p> <p>\$0 copay for one routine hearing exam every 12 months</p>
<p><b>Health and wellness education programs</b></p> <ul style="list-style-type: none"> <li>• <b>Informed Health<sup>®</sup> Line</b> Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.</li> </ul>	<p>Included in your plan</p>
<ul style="list-style-type: none"> <li>• <b>Aetna Health Connections<sup>SM</sup> – Disease Management</b> This program provides individualized clinical programs for more than 30 chronic conditions. It can help you learn about how to manage your chronic health conditions and achieve your optimal state of health</li> </ul>	<p>Included in your plan</p>

**Aetna Medicare<sup>SM</sup> Plan (PPO)  
2012 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay when you get these services from an in-network provider (after the plan deductible shown on page 1)
<ul style="list-style-type: none"> <li> <b>Healthy Outlook Program<sup>®</sup></b>                      Free educational materials and resources to help you live better with chronic conditions like diabetes, heart ailments, asthma, and low back pain.                 </li> </ul>	Included in your plan
<ul style="list-style-type: none"> <li> <b>Case Management Services</b>                      A medical condition may qualify you for an individually assigned nurse case manager who will coordinate with your physicians to help so you can get well and stay healthy.                 </li> </ul>	Included in your plan
<ul style="list-style-type: none"> <li> <b>Coaching</b> </li> </ul>	One session per week included in your plan

\*Note: See Chapter 4, Section 2.1 of the *Evidence of Coverage* for information on prior authorization rules.

## 2012 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)

### AETNA LIFE INSURANCE COMPANY

**Contract Holder Name: The City Of Seattle**

**Contract Holder Group Agreement Effective Date: January 1, 2012**

**Contract Holder Number: 430517**

This Prescription Drug Benefits Chart is part of the *Evidence of Coverage* for our plan. When the *Evidence of Coverage* refers to the attachment for details of Medicare prescription drug benefits covered under our plan, it is referring to this Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance). (See the chapters titled, "Using the plan's coverage for your Part D prescription drugs" and "What you pay for your Part D prescription drugs.")

<b>Annual deductible amount per member</b>	<b>\$0</b>
<b>Formulary Type:</b>	<b>Standard Formulary</b>
<b>Initial Coverage Limit:</b>	<b>\$2,930</b>
<b>True Out-of-Pocket Amount:</b>	<b>\$4,700</b>

## 2012 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)

**Initial Coverage Stage:** Amount you pay, up to **\$2,930** in total covered prescription drug expenses:

<b>5 Tier Plan</b>	<b>Network retail pharmacy (up to a 31-day supply)</b>	<b>Network retail or non-preferred mail order pharmacy (up to a 90-day supply)</b>	<b>Preferred mail order pharmacy (up to a 90-day supply)</b>	<b>Out-of-network pharmacy* (up to a 10-day supply)</b>
<b>Tier 1</b> Preferred Generic Drugs	<b>\$5</b>	<b>\$15</b>	<b>\$12.50</b>	<b>\$5</b>
<b>Tier 2</b> Non-Preferred Generic Drugs	<b>\$25</b>	<b>\$75</b>	<b>\$62.50</b>	<b>\$25</b>
<b>Tier 3</b> Preferred Brand Drugs	<b>\$40</b>	<b>\$120</b>	<b>\$100</b>	<b>\$40</b>
<b>Tier 4</b> Non-Preferred Brand Drugs	<b>\$65</b>	<b>\$195</b>	<b>\$162.50</b>	<b>\$65</b>
<b>Tier 5</b> Specialty Drugs	<b>25% for Generic Specialty Drugs and 25% for Brand Specialty Drugs</b>	<b>25% for Generic Specialty Drugs and 25% for Brand Specialty Drugs</b>	<b>25% for Generic Specialty Drugs and 25% for Brand Specialty Drugs</b>	<b>25% for Generic Specialty Drugs and 25% for Brand Specialty Drugs</b>

\*Coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled “Using the plan’s coverage for your Part D prescription drugs,” Section 2.5.

**Coverage Gap Stage:** Amount you pay after you reach **\$2,930** in total covered prescription drug expenses, and until you reach **\$4,700** in out-of-pocket covered prescription drug costs.

## 2012 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)

<b>5 Tier Plan</b>	<b>Network retail pharmacy (up to a 31-day supply)</b>	<b>Network retail or non-preferred mail order pharmacy (up to a 90-day supply)</b>	<b>Preferred mail order pharmacy (up to a 90-day supply)</b>	<b>Out-of-network pharmacy* (up to a 10-day supply)</b>
<b>Tier 1</b> Preferred Generic Drugs	<b>\$5</b>	<b>\$15</b>	<b>\$12.50</b>	<b>\$5</b>
<b>Tier 2</b> Non-Preferred Generic Drugs	<b>\$25</b>	<b>\$75</b>	<b>\$62.50</b>	<b>\$25</b>
<b>Tier 3</b> Preferred Brand Drugs	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>
<b>Tier 4</b> Non-Preferred Brand Drugs	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>	<b>100% of the Negotiated rate</b>
<b>Tier 5</b> Specialty Drugs	<b>86% of the Negotiated rate for Generic Specialty Drugs and 100% of the Negotiated rate for Brand Specialty Drugs</b>	<b>86% of the Negotiated rate for Generic Specialty Drugs and 100% of the Negotiated rate for Brand Specialty Drugs</b>	<b>86% of the Negotiated rate for Generic Specialty Drugs and 100% of the Negotiated rate for Brand Specialty Drugs</b>	<b>86% of the Negotiated rate for Generic Specialty Drugs and 100% of the Negotiated rate for Brand Specialty Drugs</b>

\*Coverage is limited to certain situations; see the *Evidence of Coverage* chapter titled “Using the plan’s coverage for your Part D prescription drugs,” Section 2.5.

If your plan does not include gap coverage for generic drugs, you pay no more 86% of the cost for generic drugs and the plan pays the rest. If your plan does include supplemental coverage for generic drugs, you will pay the applicable plan copay for the cost sharing tier, as shown in the chart above.

## 2012 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)

If your plan does not include gap coverage for brand drugs, you pay 50% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. If your plan does include supplemental coverage for brand drugs, the discount will be applied after your plan benefits have been determined.

**Catastrophic Coverage Stage:** Amount you pay for covered prescription drugs after reaching **\$4,700** in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount: – <i>either</i> – coinsurance of 5% of the cost of the drug – <i>or</i> – \$2.60 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.50 copayment for all other drugs.  Our plan pays the rest of the cost.

### **This Plan uses a Standard Formulary:**

Your plan uses a Standard Formulary, which means that only drugs on Aetna's Preferred Drug List will be covered under your plan as long as the drug is medically necessary and the plan rules are followed. If it is Medically Necessary for you to use a prescription drug that is eligible for coverage under the Medicare drug benefit but is not on our Formulary, you can contact Aetna to request coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2012 Group Formulary (List of Covered Drugs)* for more information.