

**Aetna MedicareSM Plan (PPO)
2013 Medical 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, 2013
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).

Annual Deductible	
This is the amount you have to pay out of pocket before the plan will pay its share for your covered medical services.	\$0

Annual Maximum Out-of-Pocket Limit	
The maximum out-of-pocket limit applies to all covered Medicare benefits including deductible	In-network maximum out-of-pocket amount: \$2,000 Combined maximum out-of-pocket amount (in- and out-of-network): \$2,000

**Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay (after deductible) when you get these services
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Important Information regarding the services listed below:

- If you receive multiple covered services during a single patient encounter with a Primary Care Physician (PCP) assigned to or selected by the member, you are responsible for a single PCP copay. If you also receive during a single patient encounter with a PCP assigned to or selected by the member, any covered services that have coinsurance, you are responsible for: (a) all coinsurance amounts applicable to covered services received during that encounter, and (b) the PCP copay for the other covered services received.
- If you receive multiple covered services during a single patient encounter with a Specialist or a Primary Care Physician (PCP) not assigned to or selected by the member, you are responsible for a single copay that is the highest copay for the covered services received. If you also receive during a single patient encounter with a Specialist or a PCP not assigned to or selected by the member, any covered services that have a coinsurance, you are responsible for: (a) all coinsurance amounts applicable to covered services received during that encounter, and (b) the highest copay of the other covered services received.
- If you receive multiple covered services during a single patient encounter, you are responsible for a single copay on the outpatient facility claim that is the highest copay for the covered services received. If you receive during a single patient encounter, any covered services that have a coinsurance, you are responsible for: (a) all coinsurance amounts applicable to covered services received during that encounter, and (b) the highest copay of the other covered services received.



You will see this apple next to the preventive services in the benefits chart.

 <p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.</p>	<p>\$0 copay</p>
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<p>Ambulance services*</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the 	
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Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>nearest appropriate facility that can provide care only 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.</p> <ul style="list-style-type: none"> • 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. • Round trip transport applies for each Medicare covered ambulance transport to a physician office or dialysis visit. <p>*Prior authorization rules apply for air ambulance transfers and non-emergency transportation by ground ambulance or medical van.</p>	<p>\$20 copay for each Medicare-covered ambulance benefit (one way)</p>
 <p>Annual wellness visit</p> <p>If you’ve had Part B for longer than 12 months, 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>Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

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 <p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 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>	<p>\$0 copay</p>
 <p>Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>\$0 copay</p>
<p>Cardiac rehabilitation services</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>	<p>\$20 copay for each Medicare-covered cardiac rehabilitation services visit</p>
 <p>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if</p>	<p>\$0 copay</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p>	
<p> Cardiovascular disease testing</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>	\$0 copay
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 12 months 	\$0 copay
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	\$15 copay per Medicare-covered visit
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema 	\$0 copay

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>as an alternative) every 24 months</p> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	
<p> Depression screening</p> <p>We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	\$0 copay
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) 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>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	\$0 copay
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions 	\$0 copay for Medicare-covered services

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>for checking the accuracy of test strips and monitors</p> <ul style="list-style-type: none"> 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. Diabetes self-management training is covered under certain conditions 	
<p>Durable medical equipment and related supplies*</p> <p>(For a definition of “durable medical equipment,” see Chapter 10 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <p>*Prior authorization rules apply for certain services; contact Member Services for information.</p>	<p>20% of the cost for each Medicare-covered item</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> Furnished by a provider qualified to furnish emergency services, and Needed to evaluate or stabilize an emergency medical condition. 	<p>\$50 copay for each Medicare-covered emergency room visit</p> <p>If you are immediately</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

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<p>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>admitted to the hospital, you pay \$0 for the emergency room visit</p>
<p> Health and wellness education programs</p> <ul style="list-style-type: none"> <p>Aetna Health ConnectionsSM — Disease Management 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.</p> 	<p>Included in your plan</p>
<ul style="list-style-type: none"> <p>Case Management Services 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.</p> 	<p>Included in your plan</p>
<ul style="list-style-type: none"> <p>Coaching One session per week.</p> 	<p>Included in your plan</p>
<ul style="list-style-type: none"> <p>Informed Health[®] Line Talk to a registered nurse 24 hours a day, 7 days a week. Get answers about medical tests, procedures and treatment options.</p> 	<p>Included in your plan</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<ul style="list-style-type: none"> Healthy Outlook Program® Free educational materials and resources to help you live better with chronic conditions like diabetes, heart ailments, asthma, and low back pain. 	Included in your plan
<ul style="list-style-type: none"> Telemonitoring for hypertension This program is designed to help you manage your high blood pressure. You will receive a free automatic blood pressure monitor, education material and support on how to control your blood pressure. 	Included in your plan
<p>Hearing services</p> <ul style="list-style-type: none"> Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Our plan covers one routine hearing exam every 12 months 	<p>\$20 copay for basic hearing evaluations</p> <p>\$0 copay for one routine hearing exam every 12 months</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> Up to three screening exams during a pregnancy 	\$0 copay
<p>Home health agency care* Prior to receiving home health services, a doctor must</p>	\$0 for each Medicare-covered home health visit, plus

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>certify that you need home health services and will order home health services to be provided by a home health agency.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>*Prior authorization rules apply.</p>	<p>applicable DME cost sharing for any covered supplies</p>
<p>Hospice care</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>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition:</u> 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>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>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal condition:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare). However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare. <p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p>	
<p>Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit. Palliative care consultation is also available.</p>	<p>Included service in Inpatient hospital care; Physician services cost sharing applies for outpatient consultations</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p>	<p>\$0 copay</p> <p>No referral needed</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	Office visit copay may apply
<p>Inpatient hospital care*</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"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • 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. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If our plan provides transplant services at a distant location (outside of the service 	<p>For Medicare-covered hospital stays, you pay:</p> <p>\$250 per admission</p>

**Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay (after deductible) when you get these services
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<p>area) 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. If you choose to obtain any transplant services that are covered by our plan from a Medicare-approved transplant center or facility that does not participate in our plan’s Institutes of Excellence™ network, we will not arrange or pay for lodging or transportation costs for you or your companion. A complete list of Medicare-approved transplant centers and facilities that participate in our Plan’s Institutes of Excellence network can be found in the Provider Directory and on our website at www.aetnaretireplans.com.</p> <ul style="list-style-type: none"> • 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 must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services 	
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<p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of 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 or 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 http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf 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>	
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Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>*Prior authorization rules apply.</p>	
<p>Inpatient mental health care*</p> <ul style="list-style-type: none"> Covered services include mental health care services that require a hospital stay. <p>*Prior authorization rules apply.</p>	<p>For Medicare-covered hospital stays, you pay: \$250 per admission</p>
<p>Inpatient services covered during a non-covered inpatient stay</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). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> Physician services Diagnostic tests (like lab tests) X-ray, radium, and isotope therapy including technician materials and services Surgical dressings Splints, casts and other devices used to reduce fractures and dislocations 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 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 Physical therapy, speech therapy, and occupational 	<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>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
therapy	
 Medical nutrition therapy <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 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 3 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 the next calendar year.</p>	\$0 copay
<p>Medicare Part B prescription drugs</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"> • 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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • 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 	\$0 per prescription or refill

**Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay (after deductible) when you get these services
<ul style="list-style-type: none"> • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • 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) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	
 <p>Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	\$0 copay
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Medicare covered routine X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Diagnostic Radiology and complex imaging such as: MRI, MRA, PET scan • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Home PT/INR monitoring is covered for chronic, oral anticoagulation management for members on warfarin with mechanical heart valves, chronic atrial fibrillation, or venous thromboembolism (inclusive 	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> - the tests/services/supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>\$20 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
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<p>of deep venous thrombosis and pulmonary embolism). The monitor and the home testing are covered for members who meet certain conditions and when it is prescribed by a doctor treating their condition.</p> <ul style="list-style-type: none"> • Blood. Coverage begins with the fourth pint of blood that you need – you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. Coverage of storage and administration begins with the first pint of blood that you need. • Other outpatient diagnostic tests <p>*Prior authorization rules apply for certain services; please contact Member Services for information.</p>	<p>\$20 copay for each Medicare-covered routine X-ray</p> <p>\$20 for each Medicare-covered diagnostic radiology and complex imaging service</p> <p>\$20 for each Medicare-covered lab service</p> <p>\$20 for each Medicare-covered diagnostic procedure or test</p> <p>\$20 copay for each Medicare-covered therapeutic radiology services</p> <p>20% of the cost for each Medicare-covered medical supply item</p> <p>\$20 for each Medicare-covered Home INR monitor/test</p> <p>\$0 copay for blood after the first 3 unreplaced pints†</p>
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<p>Outpatient hospital services</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"> • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial- 	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests/services/supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed.
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Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<ul style="list-style-type: none"> • hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself <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 http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf 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>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"> • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers • Outpatient diagnostic tests and therapeutic services and supplies
<p>Outpatient mental health care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Mental health services provided by a state-licensed psychiatrist or 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 copay for each Medicare-covered individual or group therapy visit</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational</p>	<p>\$20 copay for each Medicare-</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>covered outpatient rehabilitation service visit</p>
<p>Outpatient substance abuse services</p>	<p>\$20 copay for each Medicare-covered individual or group therapy visit</p>
<p>Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital, you should check with your provider about whether you will be an 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>Your cost share is based on:</p> <ul style="list-style-type: none"> - the tests/services/supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. <p>If you receive multiple services in one visit, you generally pay only the cost sharing of the highest-cost service.</p> <p>\$0 for Medicare-covered outpatient hospital facility visits</p> <p>\$0 for ambulatory surgical center visits</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>Partial hospitalization services</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>	<p>\$20 copay for each Medicare-covered visit</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical or surgical services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another network provider prior to surgery • 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) 	<p>Your cost share is based on:</p> <ul style="list-style-type: none"> • the tests/services/supplies you receive • the provider of the tests/services/supplies • the setting where the tests/services/supplies are performed. <p>\$20 copay for each primary care doctor visit for Medicare-covered benefits</p> <p>\$20 copay for each specialist visit for Medicare-covered benefits</p> <p>\$20 for each Medicare covered dental service</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of 	<p>\$20 copay for each Medicare-covered visit</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>injuries and diseases of the feet (such as hammer toe or heel spurs).</p> <ul style="list-style-type: none"> Routine foot care for members with certain medical conditions affecting the lower limbs 	
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test 	\$0 copay
<p>Prosthetic devices and related supplies*</p> <p>Devices (other than dental) that replace all or part of 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>	20% of the cost for each Medicare-covered item
<p>Pulmonary rehabilitation services</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</p>	\$20 copay for each Medicare-covered pulmonary rehabilitation services visit

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
treating their chronic respiratory disease.	
 <p>Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	\$0 copay
 <p>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	\$0 copay
<p>Services to treat kidney disease and conditions*</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney 	\$20 copay for kidney disease

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>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.</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • 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) <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>education services received from your PCP</p> <p>\$20 copay for kidney disease education services received from other providers</p> <p>\$20 copay 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 home dialysis equipment and supplies</p> <p>\$0 copay for Medicare-covered home support services</p>

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>Skilled nursing facility (SNF) care* (For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>100 days covered for each benefit period. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • 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.) • 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 must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services 	<p>\$0 per day 1 - 10 days</p> <p>\$25 per day 11 - 20 days</p> <p>\$50 per day 21 - 100 days</p>

**Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital. <p>*Prior authorization rules apply.</p>	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p>	<p>If you haven't been diagnosed with an illness caused or 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>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p>	<p>\$20 copay for each Medicare-covered urgently needed care visit</p>

**Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)**

Services that are covered for you	What you must pay (after deductible) when you get these services
This coverage is available world-wide.	
 Vision care Covered services include: <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • 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. • 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. (Coverage is at the Medicare Allowable rate. Contact your eye professional for assistance.) • Our plan covers one routine eye exam every 12 months. 	\$20 copay for exams to diagnose and treat diseases and conditions of the eye \$0 copay for one glaucoma screening every 12 months \$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery \$0 copay every 12 months
 “Welcome to Medicare” Preventive Visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health,	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit

Aetna MedicareSM Plan (PPO)
2013 Medical Benefits Chart (Schedule of Copayments/Coinsurance)

Services that are covered for you	What you must pay (after deductible) when you get these services
<p>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>Important: We cover the “Welcome to Medicare” preventive visit only 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” preventive visit.</p>	

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

**Aetna Medicare Plan (PPO)
2013 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, 2013
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.")

Annual deductible amount per member	\$0
Formulary Type:	Managed Standard Formulary
Initial Coverage Limit:	\$2,970
True Out-of-Pocket Amount:	\$4,750

**Aetna Medicare Plan (PPO)
2013 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

Initial Coverage Stage: Amount you pay, up to **\$2,970** in total covered prescription drug expenses:

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

*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.

Aetna Medicare Plan (PPO)

2013 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)

Coverage Gap Stage: Amount you pay after you reach **\$2,970** in total covered prescription drug expenses, and until you reach **\$4,750** in out-of-pocket covered prescription drug costs.

5 Tier Plan	Network retail pharmacy (up to a 31-day supply)	Network retail or non-preferred mail order pharmacy (up to a 90-day supply)	Preferred mail order pharmacy (up to a 90-day supply)	Out-of-network pharmacy* (up to a 31-day supply)
Tier 1 Preferred Generic Drugs	\$5	\$15	\$12.50	\$5
Tier 2 Non-Preferred Generic Drugs	\$25	\$75	\$62.50	\$25
Tier 3 Preferred Brand Drugs	47.5% of the Negotiated rate	47.5% of the Negotiated rate	47.5% of the Negotiated rate	47.5% of the Negotiated rate
Tier 4 Non-Preferred Brand Drugs	47.5% of the Negotiated rate	47.5% of the Negotiated rate	47.5% of the Negotiated rate	47.5% of the Negotiated rate
Tier 5 Specialty Drugs	25% of the Negotiated rate for Generic Specialty Drugs and 47.5% of the Negotiated rate for Brand Specialty Drugs	25% of the Negotiated rate for Generic Specialty Drugs and 47.5% of the Negotiated rate for Brand Specialty Drugs	25% of the Negotiated rate for Generic Specialty Drugs and 47.5% of the Negotiated rate for Brand Specialty Drugs	25% of the Negotiated rate for Generic Specialty Drugs and 47.5% of the Negotiated rate for Brand Specialty Drugs

*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 79% 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.

**Aetna Medicare Plan (PPO)
2013 Prescription Drug Benefits Chart (Schedule of Copayments/Coinsurance)**

If your plan does not include gap coverage for brand drugs, you pay 47.5% of the total cost (plus a portion of the dispensing fee and vaccine administration fee, if any) for brand name drugs. If your plan sponsor/former employer provides additional coverage during the Coverage Gap phase for covered brand-name drugs, you will generally continue to pay the same amount for covered brand-name drugs throughout the Coverage Gap phase of the plan as you paid in the Initial Coverage phase.

Coinsurance-based cost sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Catastrophic Coverage Stage: Amount you pay for covered prescription drugs after reaching **\$4,750** in out-of-pocket prescription drug costs.

Prescription Drug Quantity	All covered prescription drugs
Per prescription or refill	<p>Your share of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:</p> <p>–<i>either</i> – coinsurance of 5% of the cost of the drug</p> <p>–<i>or</i> – \$2.65 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.60 copayment for all other drugs.</p> <p>Our plan pays the rest of the cost.</p>

This Plan uses a Managed Standard Formulary:

Your plan uses a Managed 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. Non-preferred copayment levels may apply to some drugs on the preferred drug list. 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 a coverage exception. Your doctor must submit a statement supporting your exception request. Review the *Aetna Medicare 2013 Group Formulary (List of Covered Drugs)* for more information.