AETNA LIFE INSURANCE COMPANY

Former Employer/Union/Trust Name: **THE CITY OF SEATTLE**
Group Agreement Effective Date: **01/01/2019**
Group Number: **430517**

This Schedule of Cost Sharing 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 Medicare Part A and B services.	**No Deductible**
Annual Maximum Out-of-Pocket Limit	
The maximum out-of-pocket limit is the most you will pay for covered benefits including any deductible (if applicable).	Combined maximum out-of-pocket amount for in- and out-of-network services: $2,000

Important information regarding the services listed below in the Medical Benefits Chart:

Table 1

If you receive services from:	Your plan services include:	You will pay:
A primary care physician (PCP): • Family Practitioner • Pediatrician • Internal Medicine • General Practitioner And get more than one covered service during the single visit:	Copays only	One PCP copay.
	Copays and coinsurance	The PCP copay and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.
An outpatient facility, specialist or doctor who is not a PCP and get more than one covered service during the single visit:	Copays only	The highest single copay for all services received.
	Copays and coinsurance	The highest single copay for all services and the coinsurance amounts for each service.
	Coinsurance only	The coinsurance amounts for all services received.

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

Services that are covered for you		What you must pay (after any deductible listed on page 1) when you get these services
	Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the 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 could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **Prior authorization rules may apply for non-emergency transportation services received in-network. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of non-emergency transportation services when provided by an out-of-network provider.**	$20 copay for each Medicare-covered one-way trip.
	Annual physical exam The annual routine physical is an extensive physical exam including a medical history collection and it may also include any of the following: vital signs; observation of general appearance; a head and neck exam; a heart and lung exam; an abdominal exam; a neurological exam; a dermatological exam; and an extremities exam. Coverage for this benefit is in addition to the Medicare-covered annual wellness visit and the "Welcome to Medicare" Preventive Visit.	$0 copay for the exam.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Annual wellness visit 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. **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.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Bone mass measurement 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.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • 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.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$20 copay for each Medicare-covered cardiac rehabilitation visit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one 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 appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test in the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services • We cover manual manipulation of the spine to correct subluxation. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$15 copay per Medicare-covered visit.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy **Please Note:** A colonoscopy or sigmoidoscopy conducted for polyp removal or biopsy is a surgical procedure subject to the Outpatient surgery cost sharing. **(See "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" for more information)**	
	Dental Services Medicare covered services include: 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). **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each Medicare-covered (non-routine) dental care service.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening 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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. o When you order your LifeScan glucose monitor, you'll receive a starter kit that contains a LifeScan monitor, 10 test strips, and instructions. Work with your doctor to get a prescription for additional LifeScan test strips, which you can fill at any network pharmacy or supplier. Call LifeScan at 1-877-764-5390. Use order code: 123AET200. • 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	<u>We only cover monitors and testing supplies made by Lifescan OneTouch. We will not cover other brands unless you get prior authorization.</u> $0 copay per Medicare-covered diabetic service or supply from Lifescan OneTouch. $0 for each pair of Medicare-covered diabetic shoes/inserts. $0 copay for beneficiaries eligible for the Medicare-covered diabetes self-management training preventive benefit.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
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.	
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME 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. The most recent list of suppliers is available on our website at http://www.aetnamedicare.com/findprovider. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	20% of the cost for each Medicare-covered item.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	$90 copay for each Medicare-covered emergency room visit. If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	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. This coverage is available worldwide.	
	**Health and wellness education programs**	
	• **Aetna Health Connections℠ — Disease Management** This program provides individualized education and support for select chronic conditions. It can help you learn about how to manage your chronic health conditions and achieve your optimal state of health.	**There is no copay for any of the health and wellness education programs offered by our plan.** Included in your plan.
	• **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.	Included in your plan. Call us at **1-800-556-1555.** (For TTY/TDD assistance please dial 711.)
	• **Resources for Living ℠** – Resources For Living consultants provide research services for members on such topics as caregiver support, household services, eldercare services, activities, and volunteer opportunities. The purpose of the program is to assist members in locating local community services and to provide resource information for a wide variety of eldercare and life related issues.	Included in your plan. Call Resources for Living at **1-866-370-4842.**
	• **Written health education materials**	Included in your plan.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Hearing services • 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	$20 copay for basic hearing and balance evaluations. $0 copay for one routine hearing exam every 12 months.
	HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
	Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • 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 **Prior authorization rules may apply for network services. Your Aetna network provider is responsible**	$0 copay for each Medicare-covered home health visit. 20% of the cost for each Medicare-covered durable medical equipment item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.	
	Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: You pay your plan cost-sharing amount for these services. For services that are covered by our plan but are not covered by Medicare Part A or B: 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 prognosis. You pay your plan cost-sharing amount for these services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice*). **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit. Palliative care consultation is also available.	Hospice consultations are included as part of **inpatient hospital care**. Physician service cost sharing may apply for outpatient consultations.
	Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • 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 We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. $0 copay for other Medicare-covered Part B vaccines. You may have to pay an office visit cost-share if you get other services at the same time that you get vaccinated.
	Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of days covered by our plan. Covered services include but are not limited to:	For Medicare-covered hospital stays, you pay: $250 per stay Cost-sharing is charged for each inpatient stay.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• 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 our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. All components of blood are covered beginning with the first pint used.	

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Physician services **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. 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 https://www.medicare.gov/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. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. • There is no limit to the number of days covered by our plan. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	For Medicare-covered hospital stays, you pay: $250 per stay Cost-sharing is charged for each inpatient stay.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your skilled nursing facility (SNF) benefits or if the SNF or inpatient stay is not reasonable	$20 copay for each primary care doctor visit for Medicare-covered benefits.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
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: • 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 therapy **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each specialist visit for Medicare-covered benefits. $20 copay for Medicare-covered diagnostic procedures or tests. $20 copay for Medicare-covered lab services. $20 copay for each Medicare-covered X-ray. $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. $20 copay for Medicare-covered therapeutic radiology services. $20 copay for Medicare-covered medical supply items. 20% of the cost for each Medicare-covered prosthetic and orthotic item. 20% of the cost for each Medicare-covered DME item. $20 copay for each Medicare-covered physical, speech or occupational therapy visit.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you		What you must pay (after any deductible listed on page 1) when you get these services
	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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	
	Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
	Medicare Part B prescription drugs 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: • 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	$0 copay per prescription or refill.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
related to post-menopausal osteoporosis, and cannot self-administer the drug • 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 Part B drugs may be subject to step therapy requirements. 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 explained in Chapter 6. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	
Obesity screening and therapy to promote sustained weight loss 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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to:	Your cost-share is based on: - the tests/services/ supplies you receive

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Diagnostic Radiology and complex imaging such as: MRI, MRA, PET scan • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. All components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	- the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details. $20 copay for each Medicare-covered X-ray. $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. $20 copay for Medicare-covered lab services. $20 copay for Medicare-covered diagnostic procedures or tests. $20 copay for Medicare-covered therapeutic radiology services. $20 copay for Medicare-covered medical supply items.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital	$0 copay per facility visit. Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
• Mental health care, including care in a partial-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 drugs and biologicals that you can't give yourself **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. 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 https://www.medicare.gov/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. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details. $20 copay for each primary care doctor visit for Medicare-covered benefits. $20 copay for each specialist visit for Medicare-covered benefits. $20 copay for Medicare-covered lab services. $20 copay for Medicare-covered diagnostic procedures or tests. $20 copay for each Medicare-covered mental health care visit. $20 copay for each Medicare-covered X-ray. $20 copay for each Medicare-covered diagnostic radiology and complex imaging service. $20 copay for Medicare-covered therapeutic radiology services. $20 copay for each Medicare-covered partial hospitalization visit. $20 copay for Medicare-covered medical supply items. $0 copay per prescription or refill for certain drugs and biologicals that you can't give yourself.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
		$90 copay for each Medicare-covered emergency room visit. (Please Note: If you are immediately admitted to the hospital, you pay $0 for the emergency room visit.)
	Outpatient mental health care Covered services include: 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. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each Medicare-covered individual or group therapy visit.
	Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each Medicare-covered outpatient rehabilitation service visit.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Outpatient substance abuse services Our coverage is the same as Original Medicare which is coverage for services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Covered services include: • Assessment, evaluation, and treatment for substance use related disorders by a Medicare eligible provider to quickly determine the severity of substance use and identify the appropriate level of treatment. • Brief interventions or advice focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each Medicare-covered individual or group therapy visit.
	Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, 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."	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/supplies - the setting where the tests/services/supplies are performed. If you receive multiple services in one visit, please refer to Table 1 above for

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.	the applicable cost-sharing and coinsurance details.
		$0 copay for each Medicare-covered outpatient hospital facility visit. $0 copay for each Medicare-covered ambulatory surgical center visit.
	Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service, 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. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each Medicare-covered visit.
	Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, walk-in clinic, (non-urgent) or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare	Your cost-share is based on: - the tests/services/ supplies you receive - the provider of the tests/services/ supplies - the setting where the tests/services/ supplies are performed. If you receive multiple services in one visit, please refer to Table 1 above for the applicable cost-sharing and coinsurance details.
		$20 copay for each primary care doctor visit for Medicare-covered benefits.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	• 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) • Allergy testing **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	$20 copay for each specialist visit for Medicare-covered benefits. $20 copay for each Medicare-covered hearing and balance exams. $20 copay for each Medicare-covered (non-routine) dental care service.
	Podiatry services Medicare-covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs	$20 copay for Medicare-covered podiatry services.
	**Prostate cancer screening exams** For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.
	Prosthetic devices and related supplies 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	20% of the cost for each Medicare-covered item.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	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. **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	
	Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$20 copay for each Medicare-covered pulmonary rehabilitation visit.
	Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
	Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
	Screening for sexually transmitted infections (STIs) and counseling to prevent STIs 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. We also cover up to 2 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
	Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions	$0 copay for self-dialysis training and kidney disease education services. $20 copay for in- and out-of area outpatient dialysis.

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of the Evidence of Coverage) • 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) 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, "Medicare Part B prescription drugs." **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	Inpatient dialysis – refer to **"Inpatient hospital care"** at the beginning of this benefits chart. 20% of the cost for home dialysis equipment and supplies. $0 copay for Medicare-covered home support services.
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see the final chapter ("Definitions of important words") of the *Evidence of Coverage*. Skilled nursing facilities are sometimes called "SNFs.") We cover 100 days per benefit period. A prior hospital stay is not required.	For Medicare-covered SNF stays, you pay: $0 copay per day, day(s) 1-20; $75 copay per day, day(s) 21-100 A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when

Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
Covered services include but are not limited to: • 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. All 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 **Prior authorization rules may apply for network services. Your Aetna network provider is responsible for requesting prior authorization. Aetna recommends pre-authorization of the service when provided by an out-of-network provider.**	you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row including your day of discharge. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	service with no cost to you. Each counseling attempt includes up to four face-to-face visits. 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 two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	
	Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques • SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	You pay $20 copay per service.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Coverage is available worldwide.	$20 copay for each Medicare-covered urgent care visit received at an urgent care facility.
	**Vision care** Medicare-covered services include: • 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.	$20 copay for exams to diagnose and treat diseases and conditions of the eye.
	• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.	$0 copay for one glaucoma screening every 12 months.
	• For people with diabetes, screening for diabetic retinopathy is covered once per year.	$0 copay for one diabetic retinopathy screening every 12 months.
	• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Coverage includes conventional eyeglasses or contact lenses. Excluded is coverage for designer frames and progressive lenses instead of traditional lenses, bifocals, or trifocals. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	$0 copay for one pair of eyeglasses or contact lenses after each cataract surgery.

	Services that are covered for you	What you must pay (after any deductible listed on page 1) when you get these services
	Our plan covers one routine eye exam every 12 months.	$0 copay for one routine eye exam 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, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **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.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

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