

PCA PPO
\$10/20%/40% Rx
 PROVIDED BY AETNA LIFE INSURANCE COMPANY
 EFFECTIVE JANUARY 1, 2010 – AETNA INC. HEALTH FUND

DEDUCTIBLE, COPAYS/COINSURANCE AND DOLLAR MAXIMUMS

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|---|--|---|---|
| Deductible - per calendar year | \$0 member \$0 member + 1 \$0 family | \$1,250 member \$2,500 member + 1 \$3,750 family | \$1,250 member \$2,500 member + 1 \$3,750 family |
| Personal Care Account (PCA) Can be used to offset the annual deductible | \$400 member \$800 member + 1 \$1,200 family | \$400 member \$800 member + 1 \$1,200 family | \$400 member \$800 member + 1 \$1,200 family |
| Copays/Coinsurance • Fixed Dollar Copays | \$75 copay for: • Emergency room visits | \$75 copay for: • Emergency room visits • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions | \$75 copay for: • Emergency room visits \$150 copay for: • Outpatient surgery – facility fee only \$500 copay • Inpatient admissions |
| Percent Coinsurance | 0% | 20% | 40% of R&C Note: Services without a network are covered at the in-network level. |
| Out-of-Pocket Maximum – per calendar year • Percent Coinsurance <i>Excludes Deductible</i> | \$1,500 member \$2,250 member + 1 \$3,000 family | \$1,500 member \$2,250 member + 1 \$3,000 family | \$3,000 member \$4,500 member + 1 \$6,000 family |
| Lifetime Maximum <i>Includes Prescription Drugs</i> | \$2 million per member | | |

FACILITY OUTPATIENT DIAGNOSTIC SERVICES

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|--|--------------------------------|---------------------------------------|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Radiation Therapy | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |

EMERGENCY MEDICAL CARE

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|---|---|--|
| Hospital Emergency Room Qualified Medical Emergency & First Aid Services | Covered – 100% after \$75 copay; copay waived if admitted | Covered – 100% after \$75 copay; copay waived if admitted | Covered – 100% of R&C after \$75 copay; copay waived if admitted |
| Non-Emergency use of the Emergency Room (Please note: deductible applies only to non-emergency use of the emergency room) | Covered – 90% after \$75 copay after deductible | Covered – \$75 copay, then 80% after deductible | Covered – \$75 copay, then 60% of R&C after deductible |
| Facility Based Urgent Care Centers | Covered – 90% after deductible | Covered – 80% after deductible | Covered – 60% after deductible |
| Ambulance Services – medically necessary transport | Covered – 100% | Covered – 80% after deductible | Covered – 80% of R&C after deductible |

INPATIENT HOSPITAL CARE

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|---|--|---|
| Semi-Private Room, General Nursing Care, Hospital Services and Supplies | Covered-100% | Covered-\$250 per confinement copay, then 80% after deductible | Covered – \$500 per confinement copay, then 60% of R&C after deductible |
| | | Unlimited days | |

ALTERNATIVES TO INPATIENT HOSPITAL CARE

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--------------------------|---|--|---|
| Skilled Nursing Facility | Covered-100% | Covered – \$250 per confinement copay, then 80% after deductible | Covered – \$500 per confinement copay, then 60% of R&C after deductible |
| | | 120 days per calendar years | |
| Hospice Care | Covered – 100% | Covered – 100% | Covered – 60% of R&C after deductible |
| | | Unlimited days | |
| Home Health Care | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| | | 120 visits per calendar year | |

OUTPATIENT SURGICAL SERVICES (FACILITY FEE)

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|---|---|--|--|
| Surgery – includes related surgical services | Covered – 100% | Covered – \$75 copay, then 80% after deductible | Covered – \$150 copay, then 60% of R&C after deductible |

OUTPATIENT THERAPY

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|---|--------------------------------|---------------------------------------|
| Outpatient Physical, Speech and Occupational Therapy | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| | Limited to 60 visits each type of therapy per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility. | | |
| Cardiac Rehabilitation | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| | Maximum of 36 visits in a 12 week period | | |
| Chemotherapy | Covered – 100% | Covered -80% after deductible | Covered – 60% of R&C after deductible |

HUMAN ORGAN TRANSPLANTS

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|---|---|-------------------|-----------------------|
| Specified Organ Transplants – coordinated through the Aetna Transplant Program (1-877-212-8811) | Covered - 100% | Covered – 100% | Not Covered |
| | 1 million max per transplant type; separate from general lifetime maximum | | |

INPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|---|--|---|
| Inpatient Mental Health and Substance Abuse Care | Covered - 100% | Covered – \$250 per confinement copay, then 80% after deductible | Covered – \$500 per confinement copay, then 60% of R&C after deductible |

OTHER SERVICES

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|--|---|--------------------------------|---------------------------------------|
| Durable Medical Equipment/Medical Supplies | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Prosthetic and Orthotic Appliances | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Private Duty Nursing | Covered – 100% | Covered – 80% after deductible | Covered – 60% of R&C after deductible |

PREVENTIVE SERVICES

| | IN NETWORK | OUT OF NETWORK |
|---|----------------------------------|---|
| Health Maintenance Exam – age 18 and over; includes related chest X-rays, EKG, and lab procedures performed as part of the exam | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Annual Gynecological Exam - one per calendar year | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Pap Smear and related lab fees – one per calendar year | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Mammography Screening One baseline for ages 35-39, then one annual mammogram age 40 and over | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Prostate Specific Antigen (PSA) and DRE Screening - one per calendar year age 40 and over | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Colonoscopy Screening Exam– one every 10 years after age 50 | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Sigmoidoscopy Screening Exam – one per calendar year age 40 and over | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Well-Baby and Child Care – through age 17 <ul style="list-style-type: none"> 7 exams in the first 12 months of life 3 visits in the second 12 months of life 3 visits in the third 12 months of life 1 exam per year thereafter | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Immunizations - pediatric and adult | Covered – 100% deductible waived | Covered – 100% of R&C deductible waived |
| Routine Hearing Exam – one per calendar year | Covered – 100% | Covered – 100% of R&C after deductible |

PHYSICIAN OFFICE SERVICES

| | IN NETWORK | OUT OF NETWORK |
|--|--------------------------------|---------------------------------------|
| Office Visits Includes: <ul style="list-style-type: none"> Primary care and specialist physicians Presurgical consultations Initial visit to determine pregnancy | Covered – 80% after deductible | Covered – 60% of R&C after deductible |

PROFESSIONAL DIAGNOSTIC SERVICES

| | IN NETWORK | OUT OF NETWORK |
|--|--------------------------------|---------------------------------------|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Radiation Therapy | Covered – 80% after deductible | Covered – 60% of R&C after deductible |

MATERNITY SERVICES PROVIDED BY A PHYSICIAN

| | IN NETWORK | OUT OF NETWORK |
|-------------------------------|--------------------------------|---------------------------------------|
| Pre-Natal and Post-Natal Care | Covered – 80% after deductible | Covered – 60% of R&C after deductible |

OUTPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

| | IN NETWORK | OUT OF NETWORK |
|---------------------------------|-------------------------------|---------------------------------------|
| Outpatient Mental Health Care | Covered- 80% after deductible | Covered – 60% of R&C after deductible |
| Outpatient Substance Abuse Care | Covered- 80% after deductible | Covered – 60% of R&C after deductible |

OTHER PROFESSIONAL SERVICES

| | IN NETWORK | OUT OF NETWORK |
|---|--|---------------------------------------|
| Inpatient Medical Care (Physician visits) | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Allergy Testing and Therapy | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Injections | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Chiropractic Care | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| Physical Therapy (Independent Physical Therapist) | 20 visits per calendar year | |
| | Covered – 80% after deductible | Covered – 60% of R&C after deductible |
| | Limited to 60 visits per calendar year combined with outpatient physical therapy | |

OTHER MISC SERVICES

| | |
|--|--|
| Non Surgical Weight Management Program | Covered – 100% of billed eligible expenses up to \$500 |
| Smoking Cessation Program | Covered – 100% of billed eligible expenses up to \$500 |

PRESCRIPTION DRUGS – ADMINISTERED BY MEDCO

MEDCO MEMBER SERVICES 1.800.849.9080

| | |
|--|--|
| Retail – 34-day supply <ul style="list-style-type: none"> Generic Formulary Brand Name Non-Formulary Brand Name | 100% after \$10 copay 20% with \$20 minimum and \$70 maximum 40% with \$40 minimum and \$90 maximum |
| Mail Order – 90 day supply <ul style="list-style-type: none"> Generic Formulary Brand Name Non-Formulary Brand Name | 100% after \$25 copay 20% with \$50 minimum and \$175 maximum 40% with \$100 minimum and \$225 maximum |
| If the brand drug has a specific equivalent generic drug available and the plan participant receives the brand, then in addition to the copay, the plan participant must also pay the difference between the ingredient cost of the brand drug and the generic drug. | |
| Note: Infertility drugs are covered at 50% | |

Important Information:

Certification for certain non-preferred must be obtained in order to avoid a reduction in benefits for that care. Certification required for Hospital, Treatment Facility, and Convalescent Facility Admissions. In addition, certification is required for Home Health Care and Hospice Care.

Plan limits and maximums are combined for in-network and out-of-network care.

This plan does not cover all healthcare expenses and excludes or limits coverage for some medical services. Members should refer to their plan documents to determine which medical services are covered and to what extent. This chart displays only a general description of your benefits. Should there be a conflict between the benefits shown on the chart and those in the legal plan documents, the terms of the plan documents will be used to determine coverage and benefits.

Plans are provided by Aetna Life Insurance Company.