

**STANDARD PLAN B**  
**\$10/20%/40% Rx**

PROVIDED BY AETNA LIFE INSURANCE COMPANY  
 EFFECTIVE JANUARY 1, 2010 – AETNA INC. STANDARD OPTION B POS II

**DEDUCTIBLE, COPAYS/COINSURANCE AND DOLLAR MAXIMUMS**

	TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES	IN NETWORK	OUT OF NETWORK
<b>Deductible - per calendar year</b>	\$0 per member \$0 per family	\$750 per member \$1,500 per family	\$ 1,500 per member \$3,000 per family
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	\$35 copay • Urgent care visits \$50 copay • Outpatient surgery – facility fee only \$100 copay • Emergency room visits \$250 copay • Inpatient Admissions	\$25 copay • Health maintenance exams • Office visits • Outpatient mental health care visits \$35 copay • Urgent care visits \$100 copay • Emergency room visits • Outpatient surgery – facility fee only \$500 copay • Inpatient admissions	\$100 copay • Emergency room visits \$200 copay • Outpatient surgery – facility fee only \$1,000 copay • Inpatient admissions
• Percent Coinsurance	10%	20%	40% of R&C <b>Note:</b> Services without a network are covered at the in-network level.
<b>Out-of-Pocket Maximum – per calendar year</b> • Percent Coinsurance <i>Excludes Deductible</i>	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 per family	\$8,000 per member \$16,000 per family
<b>Lifetime Maximum</b> <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 – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Radiation Therapy	Covered – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible

## EMERGENCY MEDICAL CARE

	<b>TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES</b>	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 100% after \$100 copay; copay waived if admitted	Covered – 100% after \$100 copay; copay waived if admitted	Covered – 100% of R&C after \$100 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 - \$100 copay, then 80% after deductible	Covered – \$100 copay, then 80% after deductible	Covered – \$100 copay, then 60% of R&C after deductible
Facility Based Urgent Care Centers	Covered – 100% after \$35 copay	Covered – 100% after \$35 copay	Covered – 60% of R&C after deductible
Ambulance Services – medically necessary transport	Covered – 90%	Covered – 80% after deductible	Covered – 80% of R&C after deductible

## INPATIENT HOSPITAL CARE

	<b>TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES</b>	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered- \$250 per confinement copay, then 90%	Covered-\$500 per confinement copay, then 80% after deductible	Covered – \$1,000 per confinement copay, then 60% of R&C after deductible
	Unlimited days		

## ALTERNATIVES TO INPATIENT HOSPITAL CARE

	<b>TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES</b>	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Skilled Nursing Facility	Covered – \$250 per confinement copay, then 90%	Covered – \$500 per confinement copay, then 80% after deductible	Covered – \$1,000 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 – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	120 visits per calendar year		

## OUTPATIENT SURGICAL SERVICES (FACILITY FEE)

	<b>TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES</b>	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Surgery – includes related surgical services	Covered – \$50 copay, then 90%	Covered – \$100 copay, then 80% after deductible	Covered – \$200 copay, then 60% of R&C after deductible

## OUTPATIENT THERAPY

	<b>TRINITY HEALTH FACILITIES</b> DOES NOT INCLUDE PROFESSIONAL SERVICES	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Outpatient Physical, Speech and Occupational Therapy	Covered – 90%	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 – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	Maximum of 36 visits in a 12 week period		
Chemotherapy	Covered – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible

## HUMAN ORGAN TRANSPLANTS

	<b>TRINITY HEALTH FACILITIES</b> DOES NOT INCLUDE PROFESSIONAL SERVICES	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
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

	<b>TRINITY HEALTH FACILITIES</b> DOES NOT INCLUDE PROFESSIONAL SERVICES	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Inpatient Mental Health and Substance Abuse Care	Covered – \$250 per confinement copay, then 90%	Covered – \$500 per confinement copay, then 80% after deductible	Covered – \$1,000 per confinement copay, then 60% of R&C after deductible

## OTHER SERVICES

	<b>TRINITY HEALTH FACILITIES</b> DOES NOT INCLUDE PROFESSIONAL SERVICES	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Durable Medical Equipment/Medical Supplies	Covered – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Prosthetic and Orthotic Appliances	Covered – 90%	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Private Duty Nursing	Covered – 90%	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% after \$25 copay	Covered – 60% of R&C after deductible
Annual Gynecological Exam - one per calendar year	Covered – 100% after \$25 copay	Covered – 60% of R&C after deductible
Pap Smear Screening and related lab fees – one per calendar year	Covered – 100%	Covered – 60% of R&C after deductible
Mammography Screening One baseline for ages 35-39, then one annual mammogram age 40 and over	Covered – 100%	Covered – 60% of R&C after deductible
Prostate Specific Antigen (PSA) and DRE-One per calendar year age 40 and over	Covered – 100%	Covered – 60% of R&C after deductible
Colonoscopy Screening Exam– one every 10 years after age 50	Covered – 100%	Covered – 60% of R&C after deductible
Sigmoidoscopy Screening Exam – one per calendar year age 40 and over	Covered – 100%	Covered – 60% of R&C after deductible
Well-Baby and Child Care – through age 17 <ul style="list-style-type: none"> <li>• 7 exams in the first 12 months of life</li> <li>• 3 visits in the second 12 months of life</li> <li>• 3 visits in the third 12 months of life</li> <li>• 1 exam per year thereafter</li> </ul>	Covered – 100% after \$25 copay	Covered – 60% of R&C after deductible
Immunizations - pediatric and adult	Covered – 100%	Covered – 60% of R&C after deductible
Routine Hearing Exam – one per calendar year	Covered – 100%	Covered – 60% of R&C after deductible

## PHYSICIAN OFFICE SERVICES

	IN NETWORK	OUT OF NETWORK
Office Visits Includes: <ul style="list-style-type: none"> <li>• Primary care and specialist physicians</li> <li>• Presurgical consultations</li> <li>• Initial visit to determine pregnancy</li> </ul>	Covered – 100% after \$25 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.)	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- 100% after \$25 copay	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
	20 visits per calendar year	
Physical Therapy (Independent Physical Therapist)	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"> <li>Generic</li> <li>Formulary Brand Name</li> <li>Non-Formulary Brand Name</li> </ul>	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"> <li>Generic</li> <li>Formulary Brand Name</li> <li>Non-Formulary Brand Name</li> </ul>	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.	
<b>Note:</b> 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.