

**PCA PPO - BOISE**  
**\$10/\$20/\$40 Rx**  
 PROVIDED BY AETNA LIFE INSURANCE COMPANY  
 EFFECTIVE JANUARY 1, 2009 – AETNA INC. HEALTH FUND

**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>	\$1,250 member \$2,500 member + 1 \$3,750 family <i>(Please note: deductible applies only to non-emergency use of the emergency room)</i>	\$1,250 member \$2,500 member + 1 \$3,750 family	\$1,250 member \$2,500 member + 1 \$3,750 family
<b>Personal Care Account (PCA)</b> 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
<b>Copays/Coinsurance</b> • Fixed Dollar Copays	\$75 copay • Emergency room visits	\$75 copay • Emergency room visits • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions	\$75 copay • Emergency room visits \$150 copay • Outpatient surgery – facility fee only \$500 copay • Inpatient admissions
<b>Percent Coinsurance</b>	0%	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>	\$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
<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 – 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

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

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

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

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

	<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 – 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

	<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 - 100%	Covered – \$250 per confinement copay, then 80% after deductible	Covered – \$500 per confinement copay, then 60% of R&C after deductible
	Combined limit of 30 days per calendar year and 120 days lifetime		

## 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 – 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"> <li>• 7 exams from birth to 12 months</li> <li>• 3 exams from 13 months to 2 yrs</li> <li>• 1 exam per year for ages 3 through 17</li> </ul>	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"> <li>• Primary care and specialist physicians</li> <li>• Presurgical consultations</li> <li>• Initial visit to determine pregnancy</li> </ul>	Covered – 80% after deductible	Covered – 60% of R&C after deductible

## PROFESSIONAL DIAGNOSTIC SERVICES

	TRINITY 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

## 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**

	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
Outpatient Mental Health Care	Covered- 80% after deductible	Covered – 60% of R&C after deductible
	30 visits per calendar year	
Outpatient Substance Abuse Care	Covered- 80% after deductible	Covered – 60% of R&C after deductible
	20 visits per calendar year	

**OTHER PROFESSIONAL SERVICES**

	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>
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 – 80% of billed eligible expenses up to \$500
Smoking Cessation Program	Covered – 80% 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 100% after \$20 copay 100% after \$40 copay
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 100% after \$50 copay 100% after \$100 copay
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.