

EPO HIGH PLAN
\$10/20%/40% Rx

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

DEDUCTIBLE, COPAYS/COINSURANCE AND DOLLAR MAXIMUMS

| | TRINITY HEALTH FACILITIES DOES NOT INCLUDE PROFESSIONAL SERVICES | IN NETWORK | OUT OF NETWORK |
|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|
| Deductible - per calendar year | \$0 per member \$0 per family | \$400 per member \$800 per family | Not Applicable |
| Copays/Coinsurance • Fixed Dollar Copays | \$30 copay • Urgent care visits \$50 copay • Outpatient surgery – facility fee only \$75 copay • Emergency room visits | \$20 copay • Health maintenance exams • Office visits • Outpatient mental health care visits \$30 copay • Urgent care visits \$75 copay • Emergency room visits \$100 copay • Outpatient surgery – facility fee only \$250 copay • Inpatient admissions | \$75 copay • Emergency room visits |
| Percent Coinsurance | 0% | 20% | Not Applicable |
| Out-of-Pocket Maximum – per calendar year • Percent Coinsurance <i>Excludes Deductible</i> | \$1,000 per member \$2,000 per family | \$2,000 per member \$4,000 per family | Not Applicable |
| 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 | Not Covered |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 100% | Covered – 80% after deductible | Not Covered |
| Radiation Therapy | Covered – 100% | Covered – 80% after deductible | Not Covered |

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 - \$75 copay, then 80% after deductible | Covered – \$75 copay, then 80% after deductible | Not Covered |
| Facility Based Urgent Care Centers | Covered – 100% after \$30 copay | Covered – 100% after \$30 copay | Not Covered |
| Ambulance Services – medically necessary transport | Covered – 100% | Covered – 80% after deductible | Not Covered |

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 Unlimited days | Not Covered |

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 | Not Covered |
| | | 120 days per calendar years | |
| Hospice Care | Covered – 100% | Covered – 100% | Not Covered |
| | | Unlimited days | |
| Home Health Care | Covered – 100% | Covered – 80% after deductible | Not Covered |
| | | 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% after \$50 copay | Covered – \$100 copay, then 80% after deductible | Not Covered |

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 | Not Covered |
| 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 | Not Covered |
| Maximum of 36 visits in a 12 week period | | | |
| Chemotherapy | Covered – 100% | Covered -80% after deductible | Not Covered |

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 | Not Covered |

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 | Not Covered |
| Prosthetic and Orthotic Appliances | Covered – 100% | Covered – 80% after deductible | Not Covered |
| Private Duty Nursing | Covered – 100% | Covered – 80% after deductible | Not Covered |

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 \$20 copay | Not Covered |
| Annual Gynecological Exam - one per calendar year | Covered – 100% after \$20 copay | Not Covered |
| Pap Smear and related lab fees – one per calendar year | Covered – 100% | Not Covered |
| Mammography Screening One baseline for ages 35-39, then one annual mammogram age 40 and over | Covered – 100% | Not Covered |
| Prostate Specific Antigen (PSA) and DRE – One per calendar year age 40 and over | Covered – 100% | Not Covered |
| Colonoscopy Screening Exam– one every 10 years after age 50 | Covered – 100% | Not Covered |
| Sigmoidoscopy Screening Exam – one per calendar year age 40 and over | Covered – 100% | Not Covered |
| 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% after \$20 copay | Not Covered |
| Immunizations - pediatric and adult | Covered – 100% | Not Covered |
| Routine Hearing Exam – one per calendar year | Covered – 100% | Not Covered |

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 – 100% after \$20 copay One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.) | Not Covered |

PROFESSIONAL DIAGNOSTIC SERVICES

| | IN NETWORK | OUT OF NETWORK |
|--------------------------------------------------------|--------------------------------|----------------|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine | Covered – 80% after deductible | Not Covered |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 80% after deductible | Not Covered |
| Radiation Therapy | Covered – 80% after deductible | Not Covered |

MATERNITY SERVICES PROVIDED BY A PHYSICIAN

| | IN NETWORK | OUT OF NETWORK |
|-------------------------------|--------------------------------|----------------|
| Pre-Natal and Post-Natal Care | Covered – 80% after deductible | Not Covered |

OUTPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

| | IN NETWORK | OUT OF NETWORK |
|---------------------------------|--------------------------------|----------------|
| Outpatient Mental Health Care | Covered- 100% after \$20 copay | Not Covered |
| Outpatient Substance Abuse Care | Covered – 80% after deductible | Not Covered |

OTHER PROFESSIONAL SERVICES

| | IN NETWORK | OUT OF NETWORK |
|---------------------------------------------------|----------------------------------------------------------------------------------|----------------|
| Inpatient Medical Care (Physician visits) | Covered – 80% after deductible | Not Covered |
| Allergy Testing and Therapy | Covered – 80% after deductible | Not Covered |
| Injections | Covered – 80% after deductible | Not Covered |
| Chiropractic Care | Covered – 80% after deductible | Not Covered |
| | 20 visits per calendar year | |
| Physical Therapy (Independent Physical Therapist) | Covered – 80% after deductible | Not Covered |
| | 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% | |

Out of State Plan:

Refers to an alternative plan made available to employees residing outside of the state of Ohio who enroll in this plan. Service will be paid at the Network level provided that the Aetna network is used.

Certification Information:

Certification for certain non-preferred services must be obtained in order to avoid a reduction in benefits for that care. Certification is 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.

Referral Information:

If a Network physician or facility cannot perform a course of treatment or procedure, you must obtain an approved **referral from Aetna** prior to receiving services by a Non-Network **physician** or facility. In order to complete this process, you must contact Aetna at 1-800-544-5108. Whenever possible, a **referral** to a Trinity Health approved **physician** or facility will be provided. When that is not possible, your doctor may provide a **referral** to a Non-Network **physician** or facility. Please remember that the **referral** must be obtained prior to receiving the services

from a Non-Network **physician** or facility. Failure to obtain an approved **referral** prior to receiving services will result in no benefits being paid.

In some cases approved referrals will not be required. This would be when care is sought by covered dependent children who live outside of the Mount Carmel service area. Outside of the service area is defined as areas other than the Ohio counties of Franklin, Delaware, Licking, Pickaway, Fairfield, Union, Ross, Knox, and Madison. In these cases, care would be covered at the Network level. However, whenever possible it is recommended that preventive and elective care is done while in the Mount Carmel service area. This will provide covered individuals with the highest paid level of benefits. To ensure the accurate processing of claims, it is the responsibility of the associate to inform Aetna Insurance of any covered dependent child that resides outside of the service area.

Plans are provided by Aetna Life Insurance Company.