

EPO STANDARD PLAN
\$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
Deductible - per calendar year	\$0 per member \$0 per family	\$750 per member \$1,500 per family	Not Applicable
Copays/Coinsurance • 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
• Percent Coinsurance	10%	20%	Not Applicable
Out-of-Pocket Maximum – per calendar year • Percent Coinsurance <i>Excludes Deductible</i>	\$2,000 per member \$4,000 per family	\$4,000 per member \$8,000 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 – 90%	Covered – 80% after deductible	Not Covered
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90%	Covered – 80% after deductible	Not Covered
Radiation Therapy	Covered – 90%	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 \$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	Not Covered
Facility Based Urgent Care Centers	Covered – 100% after \$35 copay	Covered – 100% after \$35 copay	Not Covered
Ambulance Services – medically necessary transport	Covered – 90%	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- \$250 per confinement copay, then 90%	Covered-\$500 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 – \$250 per confinement copay, then 90%	Covered – \$500 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 – 90%	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 – \$50 copay, then 90%	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 – 90%	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 – 90%	Covered – 80% after deductible	Not Covered
Maximum of 36 visits in a 12 week period			
Chemotherapy	Covered – 90%	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 – \$250 per confinement copay, then 90%	Covered – \$500 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 – 90%	Covered – 80% after deductible	Not Covered
Prosthetic and Orthotic Appliances	Covered – 90%	Covered – 80% after deductible	Not Covered
Private Duty Nursing	Covered – 90%	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 \$25 copay	Not Covered
Annual Gynecological Exam - one per calendar year	Covered – 100% after \$25 copay	Not Covered
Pap Smear Screening 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 \$25 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 \$25 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 \$25 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
Physical Therapy (Independent Physical Therapist)	20 visits per calendar year	
	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.