We want you to know®
Aetna

TRINITY HEALTH
Novi, Michigan

PCA PPO – MASON CITY
$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 *Excludes Deductible*	$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 *Includes Prescription Drugs*	$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 • 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: • 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
	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 • 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
Mercy Family Pharmacies – 90 day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	 100% after $30 copay 20% with $60 minimum and $210 maximum 40% with $120 minimum and $270 maximum
Mail Order – 90 day supply • 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%	

REFERRAL PROCESS FOR MIDLAND'S CHOICE: UNIVERSITY OF IOWA HOSPITAL CLINICS / ROCHESTER, MN OR OTHER OUT-OF-NETWORK PROVIDERS REQUIRE APPROVED REFERRAL

Midland's Choice participants are required to obtain an approved referral prior to receiving services from an out-of-network provider such as the University of Iowa Hospitals and Clinics in Iowa City or a hospital / clinic associated with Rochester / Mayo Clinic. A referral is required for services provided at the hospital, as well as any physician or professional services. If a referral is not obtained prior to having services, claims will be paid at the out-of-network level.

If an associate or family member is referred to an out-of-network provider for services, the referring physician will need to send a referral to Aetna prior to services being rendered. Referrals for emergency situations will be reviewed upon receipt by Aetna (except for weekends or off hours). Non-emergency referrals will be reviewed within 48 hours of receipt by Aetna. For additional information on the referral process, contact Aetna at 800.544.5108.

IMPORTANT: An approved referral is required prior to obtaining services at an out of network provider. Failure to obtain an approved referral from Aetna will result in benefits being paid at the non-network or non-PPO level.

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.