TRADITIONAL PPO PLAN

$10/20%/40% Rx

PROVIDED BY AETNA LIFE INSURANCE COMPANY

EFFECTIVE January 1, 2021 AETNA INC. CPOS II

DEDUCTIBLE, COPAYS/COINSURANCE AND DOLLAR MAXIMUMS

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Deductible - per calendar year*	$250 per member $500 per family	$750 per member $1,500 per family	$1,500 per member $3,000 per family
Copays/Coinsurance • Fixed Dollar Copays	$20 copay • Office visits • Outpatient mental health care visits $30 copay • Specialist office visits $35 copay • Urgent care visits $100 copay • Emergency room visits • Ambulance services $50 copay • Outpatient surgery – facility fee only	$20 copay • Outpatient mental health care visits $30 copay • Office visits $35 copay • Urgent Care visits $40 copay • Specialist office visits $100 copay • Emergency room visits • Ambulance services • Outpatient surgery – facility fee only $500 copay • Inpatient admissions	$35 copay • Urgent Care visits $100 copay • Emergency room visits • Ambulance services $200 copay • Outpatient surgery – facility fee only $1,000 copay • Inpatient admissions
Percent Coinsurance	10%	20%	40% of R&C
Out-of-Pocket Maximum – per calendar year* *Includes Prescription drugs, deductible, coinsurance and copays*	$2,500 per member $5,000 per family	$4,750 per member $9,500 per family	$9,500 per member $19,000 per family
Lifetime Maximum *Includes Prescription Drugs*	None		

*** FULL INTEGRATION (DOLLARS ACCUMULATE TOWARDS ALL TIERS)**

FACILITY OUTPATIENT DIAGNOSTIC SERVICES

	TIER 1 Trinity Health facilities and Aligned Providers and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
MRI, MRA, PET and CAT Scans and Nuclear Medicine*	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible

Radiation Therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible

*Prior authorization may be required

Telemedicine

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Telemedicine A consultation between you and a **provider** who is performing a clinical medical or behavioral health service via telephonic or televideo platform	Covered – 100%	Covered – 100%	Covered – 60% of R&C after deductible

Teladoc® Care is available 24/7/365 by web, phone, and Teladoc mobile app. Teladoc.com/Aetna 1-855-835-2362	General Medical Visits – 100% Behavioral Health Visits – 100%

EMERGENCY MEDICAL CARE

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** 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 90% 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 – 100% after $35 copay
Ambulance Services – medically necessary transport	Covered – 100% after $100 copay	Covered – 100% after $100 copay	Covered – 100% after $100 copay

INPATIENT HOSPITAL CARE

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Semi-Private Room, General Nursing Care, Hospital Services and Supplies	Covered - 90% after deductible	Covered - $500 per confinement copay, then 80% after deductible*	Covered – $1,000 per confinement copay, then 60% of R&C after deductible*
	Unlimited days		

*** Tier 1 cost-share applies if admitted directly from the ER to the Hospital.**

ALTERNATIVES TO INPATIENT HOSPITAL CARE

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Skilled Nursing Facility	Covered – 90% after deductible	Covered – $500 copay, then 80% after deductible	Covered – $1,000 copay, then 60% of R&C after deductible
	120 days per calendar years		
Hospice Care	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
	Unlimited days		
Home Health Care	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	120 visits per calendar year		

OUTPATIENT SURGICAL SERVICES (FACILITY FEE)

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Surgery – includes related surgical services	Covered – $50 copay, then 90% after deductible	Covered – $100 copay, then 80% after deductible	Covered – $200 copay, then 60% of R&C after deductible

OUTPATIENT THERAPY

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Outpatient Physical, Speech and Occupational Therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	Rehabilitative: 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. Habilitative (excluding Autism): Limited to 60 visit for combined therapy types per calendar year. Services are covered when performed In a Tier 1 or Tier 2 outpatient department of the hospital, or approved freestanding facility. Precert required; Not covered in Tier 3.		
Cardiac Rehabilitation	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
	Maximum of 36 visits in a 12 week period		
Chemotherapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible

HUMAN ORGAN TRANSPLANTS

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Specified Organ Transplants – coordinated through the Aetna Transplant Program (1-877-212-8811)	Covered – 90% after deductible	Covered – 80% after deductible	No coverage for services rendered at a non-IOE Transplant facility

INPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Inpatient Mental Health and Substance Abuse Care	Covered – 90% after deductible	Covered – 90% after deductible*	Covered – $1,000 copay, then 60% of R&C after deductible

***TIER 1 DEDUCTIBLE**

OTHER SERVICES

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 OUT OF NETWORK
Durable Medical Equipment/Medical Supplies	Covered – 90% after deductible	Covered – 90% after deductible*	Covered – 60% of R&C after deductible
Prosthetic and Orthotic Appliances	Covered – 90% after deductible	Covered – 90% after deductible*	Covered – 60% of R&C after deductible
Private Duty Nursing Limited to 120 visits per calendar year	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Dialysis	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered

***TIER 1 DEDUCTIBLE**

PREVENTIVE SERVICES AS PER HEALTH CARE REFORM, PREVENTIVE SERVICES AS DEFINED BY THE U.S. PREVENTIVE SERVICES TASK FORCE PERFORMED BY AN IN-NETWORK PROVIDER WILL BE AT NO COST TO THE ASSOCIATE

	TIER 1 Trinity Health facilities and Aligned Providers	TIER 2 Select Network Providers	TIER 3 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% deductible waived	Covered – 60% of R&C after deductible
Annual Gynecological Exam - one per calendar year	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Pap Smear and related lab fees – one per calendar year	Covered – 100% deductible waived	Covered – 100% deductible waived	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% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Prostate Specific Antigen (PSA) and DRE-One Screening - one per calendar year for males 40 and over	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Colonoscopy Screening Exam– one every 10 years after age 50	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Sigmoidoscopy Screening Exam – one per calendar year age 40 and over	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible

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% deductible waived	Covered – 60% of R&C after deductible
Immunizations - pediatric and adult	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible

PHYSICIAN OFFICE SERVICES

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Office Visits Includes: • Primary care and specialist physicians • Presurgical consultations • Initial visit to determine pregnancy	Covered 100% after copay – PCP $20 copay - Specialist $30 copay. One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.)	Covered 100% after copay – PCP $30 copay - Specialist $40 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

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
MRI, MRA, PET and CAT Scans and Nuclear Medicine*	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Radiation Therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible

*Prior authorization may be required

MATERNITY SERVICES

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Pre-Natal and Post-Natal Care for physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, and fetal heart rate check)	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Delivery and Nursery Care	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
High Risk Specialist Visits	100% after $30 Copay	100% after $40 Copay	Covered – 60% of R&C after deductible

Ultrasounds and Pregnancy Diagnostic Lab Tests	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Anemia Screening and Gestational Diabetes Screening	Covered – 100% deductible waived	Covered – 100% deductible waived	Covered – 60% of R&C after deductible
Amniocentesis (Professional Charges)	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Amniocentesis (Facility Charges)	Covered – 90% after deductible after $50 copay	Covered – 80% after deductible after $100 copay	Covered – 60% of R&C after deductible after $200 copay

*Mom and Baby's claims are processed separately under their own files and both may be subject to the deductible and OOP Max.

OUTPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Outpatient Mental Health Care	Covered- 100% after $20 copay	Covered- 100% after $20 copay	Covered – 60% of R&C after deductible
Outpatient Substance Abuse Care	Covered- 100% after $20 copay	Covered- 100% after $20 copay	Covered – 60% of R&C after deductible

OTHER PROFESSIONAL SERVICES

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**TIER 3** OUT OF NETWORK
Inpatient Medical Care (Physician visits)	Covered – 90% after deductible	Covered – 80% after Deductible*	Covered – 60% of R&C after Deductible*
Allergy Testing and Therapy	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Injections	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Chiropractic Care (20 visits per calendar year)	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible
Physical Therapy -Independent Physical Therapist (Limited to 60 visits per calendar year combined with outpatient physical therapy)	Covered – 90% after deductible	Covered – 80% after deductible	Covered – 60% of R&C after deductible

***Tier 1 cost-share applies if admitted directly from the ER to the Hospital**

COVERAGE UNDER THE MEDICAL PLAN FOR DEPENDENTS THAT RESIDE OUTSIDE THE SERVICE AREA

Colleagues with dependents who reside outside of the service area are eligible to expand their Tier 2 network coverage to include more providers in their local area.

Colleagues who are enrolled in the medical plan and have dependents residing outside the service area, need to contact Customer Service Aetna with the dependent's name and address to have their contract updated and for claims to process correctly.

Note: Cancer Treatment Centers of America (CTCA) – There is no Network or Out-Of-Network coverage for both health care services provided by the facility; and health care services provided by physicians and other health care professionals at the facility.

DISEASE MANAGEMENT PROGRAM

You, and/or your covered spouse/eligible adult, can get solid support managing your condition with the Disease Management Program. This program is designed to help you control your condition in ways that work for you. You can:

- Work with a nurse when it fits your schedule
- Take online disease management programs to boost your nurse coaching sessions
- Interact with the program online, by e-mail or by phone

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.

Prescription Drugs – Administered directly by OptumRx 1-855-540-5950	
Retail – 34-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $10 copay 20% with $30 minimum and $80 maximum 40% with $60 minimum and $100 maximum *min / max reduced by 50% for asthma and diabetes
Ministry owned on-site pharmacies – 34-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $8 copay 16% with $24 minimum and $64 maximum 32% with $48 minimum and $80 maximum *min / max reduced by 50% for asthma and diabetes
Ministry owned on-site pharmacies – 90-day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $24 copay 16% with $72 minimum and $192 maximum 32% with $144 minimum and $240 maximum *min / max reduced by 50% for asthma and diabetes

Mail Order – 90 day supply • Generic • Formulary Brand Name • Non-Formulary Brand Name	100% after $25 copay 20% with $75 minimum and $200 maximum 40% with $150 minimum and $250 maximum *min / max reduced by 50% for asthma and diabetes
50% coinsurance for infertility drugs dispensed through pharmacy (no maximum) Pharmacy copays and coinsurance will track to Tier 2 out-of-pocket max	
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.	

Specialty medications must be filled at a Trinity Health pharmacy (where available) or through the OptumRx Specialty program; prescriptions limited to a 30-day supply. Specialty Customer Service number 1-877-838-2907.

Mandatory Maintenance is required for each maintenance (90 day) medication after an initial retail prescription and two refills.

Coverage of Preventive Services Medications (under the Patient Protection and Affordable Care Act (No copay):

- Prescription required –
  - Oral Fluorides (children only)
    - generic single ingredient only
  - Aspirin
    - oral over-the-counter (OTC) aspirin products (with prescription)
    - Exclude prescription aspirin products, non-oral aspirin products, or aspirin strengths > 325 mg
  - Folic Acid
    - Includes prenatal vitamins containing folic acid for adults
    - Exclude prescription folic acid supplementation products and any product containing > 0.8mg or < 0.4mg of folic acid

  - Immunizations
    - single-entity and combination vaccinations for:

Diptheria	Haemophilus influenza type B
Hepatitis A and B	Herpes zoster
Human Papillomavirus	Polio
Influenza	Measles, mumps and rubella
Meningococcal infections	Pertussis
Pneumococcal infections	Rotavirus
Tetanus	Varicella

    - Exclude vaccines not listed in the ACIP Immunization Schedules.
    - Age and/or gender limits apply in accordance with the recommendations of the ACIP to the following vaccines:
      - Haemophilus influenza type b – applies only to children < 6 years of age
      - Heplisav-B - applies only to adults ≥ 18 years of age
      - Human papillomavirus – applies to only children and adults 9 years to 26 years of age
      - Rotavirus – applies only to children < 8 months

- Shingrix – applies only to adults ≥ 50 years of age
- Zostavax-applies only to adults ≥ 60 years of age

- Bowel Preparation Medications
  - Selected OTC and Rx generic bowel preparation agents (with prescription)
  - Quantity limit of 1 bowel prep dispensing per year
  - Exclude branded bowel preparation products.
- Breast Cancer Drugs
  - Available at $0 cost-share to prevent the first occurrence of breast cancer if a Prior Authorization is obtained
  - Prior Authorization confirms member is using the medication for primary prevention of breast cancer and meets the preventive parameters of the USPSTF recommendation.
- Statins
  - For members between ages 40-75, cover lovastatin.
  - For members between ages 40-75, having one or more cardiovascular risk factors
  - Prior authorization required for $0 copay

- Prescription required –
  - Tobacco Cessation
    - prescription and over the counter (with prescription) smoking cessation products (e.g., nicotine products, bupropion [generic only], Chantix) for adults
    - quantity limit of 2 cycles per year and max daily dose applies to each active ingredient
    - Step therapy required for some products

Exclusions:

Cosmetic medication: Anti-wrinkle agents, Hair growth/removal, etc	Erectile dysfunction (ED) medications
Non-sedating antihistamine (NSA) drugs	Compound pain patches and bulk powders
Hypoactive Sexual Desire Disorder (Addyi)	

The following is a list of the drugs that need prior authorization to be covered (not intended to be an all-inclusive list): (Your physician must call 1-800-711-4555 to obtain approval for a period of up to one year)

Topical Acne	Compounds $300 and greater
Anti-obesity agents	Anabolic steroids
Kerydin	Specialty medications
Narcolepsy	Oral/Intranasal

The following is a list of most but not all of the drugs that have a quantity limit imposed:

Flu medication	Bets 2 Agonists
Corticosteroid oral inhalers	Mast cell stabilizer-Anticholinergic
Lyrica	Opiods

Due to the large number of available medicines, this list is not all-inclusive. Please note that this list does not guarantee coverage and is subject to change. Your prescription benefit plan may not cover certain products or categories, regardless of their appearance on this list.
This document is only an educational tool and should not be relied upon as legal or compliance advice.

Additionally, some PPACA requirements may differ for particular members enrolled in certain programs, and those members should consult with their plan administrators for specific details.
This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. For a complete description of benefits, please see the applicable summary plan descriptions. If there is a discrepancy between this summary and any applicable plan document, the plan document will control.
More information is available through optumrx.com to help you manage your prescription drug program. You will be able to locate a pharmacy, order mail service refills, track mail service orders, and ask questions. For additional information contact OptumRx at add 1-855-540-5950