

TRUSTMARK INSURANCE COMPANY
Diocese of Spokane
PPO Benefit Summary ~ April 1, 2011

First Choice Health Network Plan Features	PPO	
	In-Network	Out-of-Network
Plan Year Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance	80%	60%
Individual Out-of-Pocket Maximum (includes deductible)	\$2,500	\$5,000
Family Out-of-Pocket Maximum (includes deductible)	\$5,000	\$10,000
Lifetime Maximum	Unlimited	Unlimited
Physician Office Visits	\$25 copay	Deductible/Coinsurance
Urgent Care	\$25 copay	Deductible/Coinsurance
Chiropractic Services (24 visits)	\$25 copay	Deductible/Coinsurance
Acupuncture (24 visits)	\$25 copay	Deductible/Coinsurance
Preventive Care Office Visit (\$300 maximum)	\$25 copay	No Benefit
Routine Vision Exam (one per plan year)	\$25 copay	Deductible/Coinsurance
Mammograms & PSA's (one per plan year)	100%	Deductible/Coinsurance
Outpatient Diagnostic Imaging & Laboratory Services	100%	Deductible/Coinsurance
Outpatient Rehabilitative Therapies (45 visit limit)	\$25 copay	Deductible/Coinsurance
Inpatient Facility	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Facility	Deductible/Coinsurance	Deductible/Coinsurance
Retail Prescription Drug Card Services CVS Caremark 877-876-7217 (Up to a 30 Day supply)	Generic: \$15 copay Preferred Brand: \$30 copay Non-Preferred Brand: \$60 copay	
Mail Order Prescription Services CVS Caremark 877-876-7217 (Up to a 90 Day supply)	Generic: \$20 copay Preferred Brand: \$40 copay Non-Preferred Brand: \$80 copay	
Home Health Care	130 days per year; subject to deductible & coinsurance	
Skilled Nursing Care	180 days per year; subject to deductible & coinsurance	
Hospice Care	Respite: 240 hour maximum; Inpatient: 6 month limit; subject to deductible & coinsurance	
Durable Medical Equipment	Deductible/Coinsurance	Deductible/Coinsurance
Organ Transplants (OptumHealth Network)	100%	Deductible/Coinsurance
Emergency Room Access Fee Emergency Room Services	\$200 (waived if admitted) Subject to In-Network Deductible/Coinsurance	
Nervous/Mental Disorders Including Alcohol or Chemical Abuse Office Visits Inpatient/ Outpatient Treatment	\$25 Copay per office visit Deductible/Coinsurance	Deductible/Coinsurance Deductible/Coinsurance

This is a summary of your benefit program. This summary is intended for informational purposes only and does not list all of the benefits or exclusions of the plan. Any statement that conflicts with the contract is void. Please refer to the contract for a complete benefit description.