



TRADITIONAL PLAN - SAINT JOSEPH HEALTH SYSTEM - INDIANA



\$10/20%/40% Rx

PROVIDED BY AETNA LIFE INSURANCE COMPANY

EFFECTIVE January 1, 2026

Member Responsibility (Deductible, Copays/Coinsurance and Dollar Maximums)

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|---|--|---|
| Deductible - per calendar year* | \$500 per member \$1,000 per family | \$1,000 per member \$2,000 per family | N/A |
| Copays/Coinsurance Fixed Dollar Copays | <ul style="list-style-type: none"> · \$20 copay · Office visits (including telehealth) · Outpatient mental health care visits (including telehealth) · \$30 copay · Specialist office visits (including telehealth) · \$35 copay · Urgent care visits · \$50 copay · Outpatient surgery – facility fee only · \$100 copay · Ambulance services · \$200 copay · Emergency room visits | <ul style="list-style-type: none"> · \$20 copay · Outpatient mental health care visits (including telehealth) · \$30 copay · Office visits (including telehealth) · \$35 copay · Urgent care visits · \$40 copay · Specialist office visits (including telehealth) · \$100 copay · Ambulance services · Outpatient surgery – facility fee only · \$200 copay · Emergency room visits · \$500 copay · Inpatient admissions | <ul style="list-style-type: none"> · \$100 copay · Ambulance services · \$200 copay · Emergency room visits |
| Percent Coinsurance | 10% | 20%** | N/A |
| Out-of-Pocket Maximum – per calendar year* Includes Prescription drugs, deductible, coinsurance and copays | \$3,000 per member \$6,000 per family | \$5,250 per member \$10,500 per family | N/A |
| Lifetime Maximum Includes Prescription Drugs | Unlimited | | N/A |

*Full Integration (dollars accumulate towards all tiers)

** Unless otherwise stated within the summary outline

Facility & Professional Diagnostic Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|--|---|------------------------------------|----------------|
| MRI, MRA, PET and CAT Scans and Nuclear Medicine. Prior authorization may be required | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Other Diagnostic Tests, X-rays, Laboratory & Pathology | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Radiation & Chemotherapy | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Diagnostic Ultrasound & Follow Up Mammograms (after initial preventive mammogram). | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |

Telemedicine

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | 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 | \$20 copay · Office visits · Outpatient mental health care visits \$30 copay · Specialist visits | \$20 copay · Outpatient mental health care visits \$30 copay · Office visits \$40 copay · Specialist visits | Not Covered |
| Teladoc® Care is available 24/7/365 by web, phone, and Teladoc mobile app. Teladoc.com/Aetna 1-855-835-8243 | General Medical Visits – \$30 copay Behavioral Health Visits – \$20 copay Dermatology Visits – \$40 copay | | Not Covered |

Emergency Medical Care

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|--|--|---|--|
| Hospital Emergency Room Qualified Medical Emergency & First Aid Services | Covered – 100% after \$200 copay; copay waived if admitted | Covered – 100% after \$200 copay; copay waived if admitted. Applies to Tier 1 Out-of-Pocket Maximum | Covered – 100% of R&C after \$200 copay; copay waived if admitted. Applies to Tier 1 Out-of-Pocket Maximum |
| Non-Emergency use of the Emergency Room (Please note: deductible applies only to non-emergency use of the emergency) | Covered - \$200 copay, then 90% after deductible | Covered – \$200 copay, then 80% after deductible | Not Covered |
| Facility Based Urgent Care Centers | Covered – 100% after \$35 copay | Covered – 100% after \$35 copay. Applies to Tier 1 Out-of-Pocket Maximum. | Not Covered |
| Ambulance Services – medically necessary transport | Covered – 100% after \$100 copay | Covered – 100% after \$100 copay. Applies to Tier 1 Out-of-Pocket Maximum | Covered – 100% after \$100 copay. Applies to Tier 1 Out-of-Pocket Maximum |

Hospital Care

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | 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 | Not Covered |
| | Unlimited Days | | |
| Inpatient Admission via Emergency Room | Covered - 90% after deductible | Covered - 90% after Tier 1 deductible. Applies to Tier 1 Out-of-Pocket Maximum | Covered - 90% after Tier 1 deductible. Applies to Tier 1 Out-of-Pocket Maximum |
| | Unlimited Days | | |
| Inpatient Medical Care (Physician Visits) | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |

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

Alternatives To Hospital Care

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|--------------------------|---|--|----------------|
| Skilled Nursing Facility | Covered – 90% after deductible | Covered – \$500 copay, then 80% after deductible | Not Covered |
| | 120 days per calendar year | | |
| Hospice Care | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| | Unlimited days | | |
| Home Health Care | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| | 120 visits per calendar year | | |

Surgical Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|--|--|--|----------------|
| Surgery – includes related surgical services | Covered – \$50 copay, then 90% after deductible | Covered – \$100 copay, then 80% after deductible | Not Covered |
| Inpatient Bariatric Surgery - Covered only if performed at a Tier 1 Trinity Health facility or an Aetna IOQ designated facility at Tier 2 | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Outpatient Bariatric Surgery - Covered only if performed at a Tier 1 Trinity Health facility or an Aetna IOQ designated facility at Tier 2 | Covered – \$50 copay then 90% after deductible | Covered – \$100 copay then 80% after deductible | Not Covered |
| Sterilization-Males Only; excludes reversal sterilization | Not Covered | Not Covered | Not Covered |
| Sterilization-Females Only; excludes reversal sterilization | Not Covered | Not Covered | Not Covered |

Therapy Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|---|------------------------------------|----------------|
| Outpatient Physical, Speech and Occupational Therapy. Services need to be provided at a Trinity facility to be paid Tier 1. | Covered – 90% after deductible | 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. No visit limit on autism, mental health or substance abuse diagnoses. | | |
| Cardiac Rehabilitation | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| | Maximum of 36 visits in a 12 week period | | |

Autism Spectrum Disorders, Diagnoses and Treatment

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|--|---|----------------|
| Applied Behavioral Analysis (ABA) | Covered – 100% after \$20 PCP copay | Covered – 100% after \$20 PCP copay Applies to Tier 1 Out-of-Pocket Maximum | Not Covered |
| Physical, Occupational and Speech Therapy | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Nutritional Counseling | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |

Human Organ Transplants

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|--|------------------------------------|----------------|
| Specified Organ Transplants – coordinated through the Aetna Transplant Program (1-877-212-8811) | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Kidney, Cornea, Bone Marrow and Skin | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |

Behavioral Health Services (Mental Health and Substance Use Disorder)

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|--|---|----------------|
| Inpatient Mental Health and Substance use disorder treatment | Covered – 90% after deductible | Covered – 90% after Tier 1 deductible. Applies to Tier 1 Out-of-Pocket Maximum. | Not Covered |
| Outpatient Mental Health and Substance use disorder treatment (includes telehealth visits) | Covered- 100% after \$20 copay | Covered- 100% after \$20 copay Applies to Tier 1 Out-of-Pocket Maximum | Not Covered |
| Spring Health: Mental Health Visits · Virtual or In-Person visits rendered by a Spring Health provider · Services after 6 Trinity Health sponsored visits | Covered - 100% after \$20 copay | N/A | N/A |
| Spring Health: Substance Use Disorder · Virtual visits rendered by a Spring Health provider | Covered - 100% after \$20 copay | N/A | N/A |
| Spring Health is not an Aetna product and contracts separately with Trinity Health | | | |

Preventive Care Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | 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 | Not Covered |
| Annual Gynecological Exam - one per calendar year | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Pap Smear and related lab fees – one per calendar year | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Mammography Screening – No age or frequency limit (includes 3D Mammography) | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Preventive Ultrasound two dense breast ultrasounds (1 left and 1 right). Must have history of preventive mammogram within the last 6 months or service will apply deductible/coinsurance. | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Prostate Specific Antigen (PSA) and DRE – No age or frequency limit | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Colonoscopy Screening Exam – one every 10 years after age 45 | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Sigmoidoscopy Screening Exam – One exam every 5 years age 45 and over | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| 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 | Not Covered |
| Immunizations - pediatric and adult | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Routine Hearing Exam – one per calendar year | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Contraceptive Methods and Counseling | Not Covered | Not Covered | Not Covered |

Physician Office Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|---|--|----------------|
| Office Visits Includes: · Primary care and specialist physicians · Presurgical consultations · Initial visit to determine pregnancy · Office consultations | Covered 100% after copay – PCP \$20 copay - Specialist \$30 copay. One copay may apply 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 may apply to the office visit exam and all services performed during the office visit (e.g., lab, x-ray, etc.) | Not Covered |

Maternity Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | 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 | Not Covered |
| Delivery and Nursery Care | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| High Risk Specialist Visits | Covered -100% after \$30 Copay | Covered - 100% after \$40 Copay | Not Covered |
| Ultrasounds and Pregnancy Diagnostic Lab Tests | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Anemia Screening and Gestational Diabetes Screening | Covered – 100% deductible waived | Covered – 100% deductible waived | Not Covered |
| Amniocentesis (Professional Charges) | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Amniocentesis (Facility Charges) | Covered – \$50 copay then 90% after deductible | Covered – \$100 copay then 80% after deductible | Not Covered |

*Mom and Baby's claims are processed separately under their own files, and both may be subject to the deductible and out of pocket maximum.

Other Services

| | TIER 1 Trinity Health Facilities and Aligned Providers | TIER 2 Select Network Providers | Out of Network |
|---|--|---|----------------|
| Allergy Testing and Therapy | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Allergy Injections | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Chiropractic Care (20 visits per calendar year) | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Durable Medical Equipment/Medical Supplies | Covered – 90% after deductible | Covered – 90% after Tier 1 deductible. Applies to Tier 1 Out-of-Pocket Maximum. | Not Covered |
| Prosthetic and Orthotic Appliances | Covered – 90% after deductible | Covered – 90% after Tier 1 deductible. Applies to Tier 1 Out-of-Pocket Maximum. | Not Covered |
| Private Duty Nursing Limited to 120 visits per calendar year | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |
| Dialysis | Covered – 90% after deductible | Covered – 80% after deductible | Not Covered |

REQUIRED REFERRAL / PRIOR AUTHORIZATION PROCESS FOR RILEY HOSPITAL FOR CHILDREN OR OTHER OUT-OF- NETWORK PROVIDERS

This plan has no out-of-network benefits. All participants need to obtain an approved out-of-network referral/prior authorization for payment at the Tier 2 in-network benefit level before receiving services at Riley Hospital or Children Hospitals and Clinics or Beacon Health System (Elkhart General Hospital or Memorial Hospital) facilities. If you do not obtain an approved referral before receiving care, your claims will be denied. Also, all other out-of-network providers will be denied for services provided by their facilities and physicians unless it is identified that the service is not available by any other Tier 1 or Tier 2 provider.

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 at 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) are now part of City of Hope- There is no coverage for both health care services provided by the facility and health care services provided by physicians and other health care professionals at any of their facilities, with the exception of the City of Hope National Medical Center, general acute care hospitals in Duarte and Irvine, CA.

Mayo Clinic – There is no in-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 any of their facilities.

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.

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.

Traditional Prescription Plan

Prescription Drug Benefit administered by OptumRx

1-855-540-5950

www.optumrx.com

34-day supply

| | |
|---------------------|--|
| Generic | TH retail: \$8 All other: \$10 |
| Brand Formulary | TH retail: 16% (\$24 min/\$80 max) All other: 20% (\$30 min/\$100 max) |
| Brand Non-Formulary | TH retail: 32% (\$48 min/\$120 max) All other: 40% (\$60 min/\$150 max) |

90-day supply

| | |
|---------------------|--|
| Generic | TH retail: \$24 All other: \$25 |
| Brand Formulary | TH retail: 16% (\$72 min/\$240 max) All other: 20% (\$75 min/\$250 max) |
| Brand Non-Formulary | TH retail: 32% (\$144 min/\$360 max) All other: 40% (\$150 min/\$375 max) |

Notes:

Out-of-Pocket Maximum (OOPM)*: \$5,250 single/\$10,500 family

*Combined with medical OOPM

Infertility medications have a 50% coinsurance (no maximum)

Dispense as Written (DAW): If the brand drug has a specific equivalent generic drug available and the plan participant receives the brand, the plan participant must pay the difference between the ingredient cost of the brand drugs and the generic drug along with the regular copay.

Maintenance Drugs

Prescription Drugs that are taken on an ongoing basis to treat routine ailments or disorders are considered to be a maintenance medication.

After three 30-day fills, the member will be required to fill the medication as a 90-day supply through OptumRx Mail Service Pharmacy, CVS retail pharmacies (for certain Ministries) or a Trinity Health retail pharmacy, including Trinity Health Pharmacy Services in Ft. Wayne, IN.

Specialty Drugs

Specialty medications must be filled through Trinity Health Pharmacy Services in Ft. Wayne or Trinity Health retail pharmacies (certain ministries) or through the OptumRx Specialty program (certain ministries).

Preventive Service Medications (under the Patient Protection and Affordable Care Act):

No Copay with Prescription

- Aspirin Products
 - o Aspirin for prevention of morbidity and mortality from preeclampsia in pregnant women at risk. Oral over-the-counter (OTC) aspirin products (with prescription). Exclude prescription aspirin products, non-oral aspirin products, or aspirin strengths > 325 mg
- Fluoride Products
 - o Fluoride for prevention of dental caries in children. Prescription (generic single ingredient only) oral fluoride supplementation products. Exclude branded oral fluoride supplementation products
- Folic Acid & Prenatal Vitamins
 - o Folic acid for prevention of neural tube defects. OTC folic acid supplementation products (with prescription), including 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
- Tobacco Smoking Cessation Products
 - o Prescription and OTC (with prescription) tobacco smoking cessation products (e.g., nicotine products, bupropion [generic only], varenicline) for adults. Quantity limit of 2 cycles per year and max daily dose applies to each
- Immunizations
 - o Cover at \$0 copay, single-entity and combination vaccinations for diphtheria, haemophiles influenzae type b, hepatitis A, hepatitis B, herpes zoster, human papillomavirus, polio, influenza, measles, mumps, rubella, meningococcal infections, pertussis, pneumococcal infections, rotavirus, tetanus, varicella monkeypox and COVID-19 vaccines with FDA approval. Exclude vaccines not listed in the ACIP Immunization Schedules. Age edits will apply in accordance with recommendations from ACIP.
- Bowel Prep Agents for Colorectal Cancer Screening
 - o Selected OTC and Rx generic bowel preparation agents. Quantity limits may apply. Exclude branded bowel preparation products.
- Breast Cancer-primary preventive
 - o 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
 - o Low to moderate dose statins for the primary prevention of cardiovascular disease in adults.
 - o For members between ages 40-75, cover lovastatin
 - o For members between ages 40-75, having one or more cardiovascular risk factors
 - § Risk factors such as dyslipidemia, diabetes, hypertension, or smoking, and having a calculated 10-year risk of a cardiovascular event of 10% or greater, cover atorvastatin (generic Lipitor) 10 & 20 mg and simvastatin (generic Zocor) 5, 10, 20, 40 mg.
 - o Requires prior authorization for \$0 cost share
- Pre-exposure Prophylaxis (PrEP)-prevention of HIV infection
 - o To include generic tenofovir disoproxil fumarate and tenofovir. Brands Truvada, Descovy, and Apretude available if unable to take the generic.
 - o Requires prior authorization for \$0 cost share

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Excluded Drugs

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

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Drugs requiring Prior Authorization (PA)

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

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

Drugs that have Quantity Limits (QL) imposed

- Flu medication
- Corticosteroid oral inhalers
- Pregablin
- Bets 2 Agonists
- Mast cell stabilizer-Anticholinergic
- Opioids

For a complete list, please reach out to OptumRx at 855-540-5950 or visit www.optumrx.com

GLP-1 medications for diabetes and obesity

GLP-1 medications to treat diabetes or obesity are limited to be filled at a 30-day supply only.

Nicotine Cessation

Nicotine cessation medications, excluding OTC products, will be filled at appropriate tier level once Healthcare Reform (HCR) \$0 benefit has been exhausted.

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 is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract and is intended to be reviewed with the applicable summary plan description. Additional limitations and exclusions may apply. For a complete description of benefits, please review the applicable summary plan description. 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 1-855-540-5950.