MERCY MEDICAL CENTER - DUBUQUE
TRADITIONAL PLAN
$10/20%/40% RX

PROVIDED BY PREFERRED HEALTH CHOICES
EFFECTIVE JANUARY 1, 2025

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	Not Applicable
Copays/Coinsurance • Fixed Dollar Copays	$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	$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 • Outpatient surgery – facility fee only • Ambulance Services $200 copay • Emergency room visits $500 copay • Inpatient admissions	$100 copay • Ambulance Service $200 copay • Emergency room visits
Percent Coinsurance	10%	20%**	Not Applicable
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	Not Applicable
Lifetime Maximum *Includes Prescription Drugs*	Unlimited		Not Applicable

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

****UNLESS OTHERWISE STATED WITHIN THE SUMMARY OUTLINE**

FACILITY AND 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. *Services need to be provided at a Trinity facility to be paid as Tier 1.*	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
Other Diagnostic Tests, X-rays, Laboratory & Pathology. *Services need to be provided at a Trinity facility to be paid as Tier 1.*	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered

Diagnostic Ultrasound and follow-up mammograms (after initial preventive mammogram). *Services need to be provided at a Trinity facility to be paid as Tier 1.*	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
Radiation and Chemotherapy	Covered – 90% after deductible	Covered – 80% after deductible	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% 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 room)	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; no deductible	Covered – 100% after $35 copay; no deductible. Applies to Tier 1 Out-of-Pocket Maximum	Not Covered
Ambulance Services – medically necessary transport	Covered – 100% after $100 copay; no deductible	Covered – 100% after $100 copay; no deductible. Applies to Tier 1 Out-of-Pocket Maximum	Covered – 100% after $100 copay; no deductible. 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
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

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 years		Not Applicable
Hospice Care	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
	Unlimited days		Not Applicable
Home Health Care	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
	120 visits per calendar year		Not Applicable

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 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 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 as 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.		Not Applicable
Habilitative Services *Services need to be provided at a Trinity facility to be paid as Tier 1.*	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
	Limited to 60 visits combined physical, occupational and speech 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.		Not Applicable

HUMAN ORGAN TRANSPLANTS

	TIER 1 Trinity Health facilities and Aligned Providers	**TIER 2** Select Network Providers	**OUT OF NETWORK**
Specified Organ Transplants – (Utilization of a designated transplant network is required)	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	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	Not Applicable	Not Applicable
Spring Health: Substance Use Disorder • Virtual visits rendered by a Spring Health provider	Covered – 100% after $20 copay	Not Applicable	Not Applicable
Spring Health is not a Health Choices product and contracts separately with Trinity Health			

AUTISM SPECTRUM DISORDERS, DIAGNOSIS 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

PREVENTIVE 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 lab procedures performed as part of the exam	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
Annual Gynecological Exam – includes pap smear and related lab fees – one per calendar year	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
Mammography Screening One baseline for ages 35-39, then one annual mammogram age 40 and over 3D mammograms are covered under the Plan	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered

Preventive Ultrasound Two dense breast ultrasounds (one LT and one RT). Must have history of a preventive mammogram within the last six months or service will apply deductible/ coinsurance.	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
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	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 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	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
Immunizations pediatric and adult – travel exams & travel immunizations are not covered	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
Routine Hearing Exam – covered when medically necessary	Covered – 100% deductible waived	Covered – 100% deductible waived	Not Covered
Contraceptives 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 • Pre-surgical 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 – 90% after deductible after $50 copay	Covered – 80% after deductible after $100 copay	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**
Cardiac Rehabilitation	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
	Maximum of 36 visits in a 12-week period		Not Applicable
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 Care Limited to 120 days per calendar year	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
Dialysis	Covered – 90% after deductible	Covered – 80% after deductible	Not Covered
Telehealth	PCP $20 copay - Office visit - Outpatient mental health care visits Specialist $30 copay	$20 Outpatient mental health care visits PCP $30 copay - Office visits Specialist $40 copay	Not Covered

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 Health Choices 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 Hospital.

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.

Plans are provided by Preferred Health Choices.

Traditional Prescription Plan

Prescription Drug Benefit administered by OptumRx **1-855-540-5950** **www.optumrx.com**

		Current State
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)
	Obesity Medications	TH retail: 32% ($48 min/$320 max) All other: 40% ($60 min/$400 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)
	Obesity Medications	TH retail: 32% ($144 min/$960 max) All other: 40% ($150 min/$1,000 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 drug. After three 30-day fills, the member will be required to fill the drug 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
  - 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
  - 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
  - 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
  - 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 active ingredient.
- Immunizations
  - 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, respiratory syncytial virus, 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
  - Selected OTC and Rx generic bowel preparation agents. Quantity limits may apply. Exclude branded bowel preparation products.
- Breast Cancer-primary preventive
  - 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
  - Low to moderate dose statins for the primary prevention of cardiovascular disease in adults.
  - For members between ages 40-75, cover lovastatin
  - 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.
  - Requires prior authorization for $0 cost share
- Pre-exposure Prophylaxis (PrEP)-prevention of HIV infection
  - To include generic tenofovir disoproxil fumarate and tenofovir. Brand Truvada, Descovy, and Apretude are available if unable to take generics listed.
  - 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
- Medications and products available over-the-counter (OTC)

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.