Health Plans

[Group Legal Name]

IU Health Plans Gold 2500

Schedule of Benefits

This Schedule of Benefits is a summary of the Subscriber's Benefits and Cost Sharing provided under the Group Contract. The definitions, i.e., Coinsurance, Copayment, Deductible, Out-of-Pocket Maximum, stated in the Subscriber's Evidence of Coverage (EOC) apply to this Schedule of Benefits. Tier 1 benefits apply when Covered Services are provided by Participating Providers, except as indicated under the "Cost Sharing and Limitations" provision in this Schedule of Benefits.

Services provided by Non-Participating Providers are Non-Covered Services unless specifically covered under the Group Contract. The Enrollee is responsible for all expenses for Non-Covered Services.

Effective Date: 01/01/2023

Plan Year: 01/01/2023 through 12/31/2023

DEDUCTIBLE ([Per Calendar Year][Per Plan Year])	
Family Status	**Tier 1**
Per Enrollee	**$2,500**
Per Family	**$5,000**

OUT-OF-POCKET MAXIMUM ([Per Calendar Year][Per Plan Year])	
Family Status	**Tier 1**
Per Enrollee	**$4,400**
Per Family	**$8,800**

Cost Sharing and Limitations: Cost Sharing is the Copayment and Coinsurance that the Enrollee must pay for Covered Services. Some Covered Services are subject to limitations. Health Care Services received from Non-Participating Providers are Non-Covered Services unless the Evidence of Coverage specifically provides otherwise. See Article 6 Section D. of the Evidence of Coverage for additional information on when Health Care Services received from Non-Participating Providers may be Covered Services. If Health Care Services received from Non-Participating Providers are determined to be Covered Services, the services are subject to the same Deductibles, Copayments, Coinsurance and limitations as Covered Services received from Participating Providers.

Refer to the Evidence of Coverage for more detailed benefit information.

Benefit	Tier 1 Benefits Cost Sharing per Enrollee
Ambulance Services	10% Coinsurance after Deductible
Behavioral Health Services	
Outpatient Services	$20 Copayment
Inpatient Services	5% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	$20 Copayment
Substance Abuse Disorder Inpatient Services	5% Coinsurance after Deductible
Dental Services for Accidental Injury	10% Coinsurance after Deductible
Diabetic Equipment, Education and Supplies	Copayments/Coinsurance based on setting where Covered Services are received. For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule. For information on Diabetic education, please refer to the “Specialty Physician" or "Primary Care Physician" provisions in this Schedule. For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.
Diagnostic Services	
Laboratory Services	10% Coinsurance after Deductible
Radiology Services	10% Coinsurance after Deductible
X-ray Services	10% Coinsurance after Deductible
Emergency Services	
Emergency Room - *Cost*	$300 copayment (waived if admitted); Benefit is subject to the Deductible after Copayment
Urgent Care Center Services	$50 Copayment
Home Care Services	
Home Care Visits - *limited to a maximum of 100 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Enrollee Per Year and 164 visits per Enrollee per lifetime*	10% Coinsurance after Deductible
Hospice Services	10% Coinsurance after Deductible
Inpatient Services	
Inpatient Facility Services	10% Coinsurance after Deductible

Benefit	Tier 1 Benefits Cost Sharing per Enrollee
Inpatient Physician and Surgical Services	10% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Enrollee Per Year*	10% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Enrollee Per Year*	10% Coinsurance after Deductible
Maternity Services	
Prenatal and Postnatal Care	10% Coinsurance after Deductible
Delivery and Inpatient Services	10% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances	
Medical Supplies	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible
Prosthetics	10% Coinsurance after Deductible
Orthotic Devices	10% Coinsurance after Deductible
Outpatient Services	
Outpatient Facility	10% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	10% Coinsurance after Deductible
Physician Visits	
Primary Care Physician	$30 Copayment
Specialty Physician	$60 Copayment
Mental/Behavioral Health and Substance Abuse Disorder Office Visits	$20 Copayment
Preventive Care Services	$0 Enrollee Cost Sharing
Surgical Services	10% Coinsurance after Deductible
Telehealth Services	
First Telehealth Visit	No Charge
Follow-Up Telehealth Visit	$10 Copayment
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	10% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative	
Physical Medicine Services - *limited to a maximum of 60 visits per Enrollee Per Year*	10% Coinsurance after Deductible

Benefit	Tier 1 Benefits Cost Sharing per Enrollee
Physical Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Manipulation Therapy - *limited to a maximum of 12 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Rehabilitation Services	
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Enrollee Per Year*	5% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Enrollee Per Year*	5% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative	
Physical Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	10% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services	
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Participating Provider Agreement. Contact the Case Manager for specific Participating Provider information for Health Care Services received at or coordinated by a Participating Provider Facility or starts one day prior to a Covered Transplant Procedure and continues to the date of discharge at a Non-Participating Provider Facility.
Deductible	Not Applicable

Benefit	Tier 1 Benefits Cost Sharing per Enrollee
Covered Transplant Procedure during the Transplant Benefit Period	During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the Health Care Service is performed.
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services – Professional and Ancillary (non-Hospital) Providers	
Covered Transplant Procedure During the Transplant Benefit Period	No Copayment/Coinsurance up to the Allowed Amount
Transportation and Lodging	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	10% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit
Live Donor Health Services	Covered as determined by the Contract
Prescription Drugs	
Retail – *30 day supply- IU Health Pharmacies*	
Tier 1 (Preferred Generic)	$3 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$10 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	$25 Copayment per Prescription Order
Tier 4 (Non-Preferred Brand Name)	$50 Copayment per Prescription Order
Tier 5 (Specialty)	20% Coinsurance to maximum of $350 per Prescription Order after Deductible
Tier 6 (Preventive)	$0 Enrollee Cost Sharing
Retail – *30 day supply- CVS Caremark Advanced Choice Pharmacies*	
Tier 1 (Preferred Generic)	$5 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$15 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	$35 Copayment per Prescription Order
Tier 4 (Non-Preferred Brand Name)	$70 Copayment per Prescription Order
Tier 5 (Specialty)	35% Coinsurance to maximum of $350 per Prescription Order after Deductible
Tier 6 (Preventive)	$0 Enrollee Cost Sharing

Benefit	Tier 1 Benefits Cost Sharing per Enrollee
Mail Order – *90 day supply*	
Tier 1 (Preferred Generic)	$12.50 Copayment per Prescription Order
Tier 2 (Non-Preferred Generic)	$37.50 Copayment per Prescription Order
Tier 3 (Preferred Brand Name)	$87.50 Copayment per Prescription Order
Tier 4 (Non-Preferred Brand Name)	$175 Copayment per Prescription Order
Tier 5 (Specialty)	Limited to 30 Day Supplies
Tier 6 (Preventive)	$0 Enrollee Cost Sharing
Pediatric Vision (Benefits available for Enrollees until the first day of the month after they obtain the age of 19)	
Eye exam - *limited to 1 exam per Enrollee per Year*	$0 Enrollee Cost Sharing
Eyeglass Lenses - *limited to 1 set of lenses per Enrollee per Year*	$0 Enrollee Cost Sharing
Eyeglass Frames - *limited to 1 set of frames per Enrollee Per Year*	$0 Enrollee Cost Sharing for Provider designated frames
Contact Lenses - *includes materials only, covered once per Enrollee Per Year in lieu of eyeglasses*	$0 Enrollee Cost Sharing for designated contact lenses
Conventional	One pair annually from selection of designated contact lenses
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses