



# Health Plans

[Group Legal Name]

**IU Health Plans Gold 500**

## 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

| <b>DEDUCTIBLE</b><br><b>([Per Calendar Year][Per Plan Year])</b> |                |
|------------------------------------------------------------------|----------------|
| <b>Family Status</b>                                             | <b>Tier 1</b>  |
| <b>Per Enrollee</b>                                              | <b>\$500</b>   |
| <b>Per Family</b>                                                | <b>\$1,000</b> |

| <b>OUT-OF-POCKET MAXIMUM</b><br><b>([Per Calendar Year][Per Plan Year])</b> |                 |
|-----------------------------------------------------------------------------|-----------------|
| <b>Family Status</b>                                                        | <b>Tier 1</b>   |
| <b>Per Enrollee</b>                                                         | <b>\$9,100</b>  |
| <b>Per Family</b>                                                           | <b>\$18,200</b> |

**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.**

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Schedule of Benefits (continued)

| Benefit                                                                                                                          | Tier 1 Benefits<br>Cost Sharing per Enrollee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Ambulance Services                                                                                                               | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Behavioral Health Services                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Outpatient Services                                                                                                              | \$20 Copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Inpatient Services                                                                                                               | 20% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Substance Abuse Disorder Outpatient Services                                                                                     | \$20 Copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Substance Abuse Disorder Inpatient Services                                                                                      | 20% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Dental Services for Accidental Injury                                                                                            | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Diabetic Equipment, Education and Supplies                                                                                       | <p>Copayments/Coinsurance based on setting where Covered Services are received.</p> <p>For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment, and Appliances" provision in this Schedule.</p> <p>For information on Diabetic education, please refer to the "Specialty Physician" or "Primary Care Physician" provisions in this Schedule.</p> <p>For information on Prescription Drug Coverage, please refer to the "Prescription Drugs" provision in this Schedule.</p> |
| Diagnostic Services                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Laboratory Services                                                                                                              | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Radiology Services                                                                                                               | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| X-ray Services                                                                                                                   | 30% 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                                                                                                      | \$60 Copayment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Home Care Services                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Home Care Visits - <i>limited to a maximum of 100 visits per Enrollee Per Year</i>                                               | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Private Nursing Visits - <i>limited to a maximum of 82 visits per Enrollee Per Year and 164 visits per Enrollee per lifetime</i> | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Hospice Services                                                                                                                 | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Inpatient Services                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Inpatient Facility Services                                                                                                      | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

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Schedule of Benefits (continued)

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

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Schedule of Benefits (continued)

| Benefit                                                                                   | Tier 1 Benefits<br>Cost Sharing per Enrollee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>         | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Speech Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>           | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Occupational Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>     | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Manipulation Therapy - <i>limited to a maximum of 12 visits per Enrollee Per Year</i>     | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Rehabilitation Services                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Cardiac Rehabilitation - <i>limited to a maximum of 36 visits per Enrollee Per Year</i>   | 20% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Pulmonary Rehabilitation - <i>limited to a maximum of 20 visits per Enrollee Per Year</i> | 20% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Therapy Services – Outpatient Habilitative                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Physical Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>         | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Speech Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>           | 30% Coinsurance after Deductible                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Occupational Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>     | 30% 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                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

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**Schedule of Benefits (continued)**

| <b>Benefit</b>                                                                                                                  | <b>Tier 1 Benefits<br/>Cost Sharing per Enrollee</b>                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Covered Transplant Procedure during the Transplant Benefit Period                                                               | During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount.<br>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. |
| <b>Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services – Professional and Ancillary (non-Hospital) Providers</b> |                                                                                                                                                                                                                                                                                                                           |
| Covered Transplant Procedure During the Transplant Benefit Period                                                               | No Copayment/Coinsurance up to the Allowed Amount                                                                                                                                                                                                                                                                         |
| Transportation and Lodging                                                                                                      | 30% 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                               | 30% 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                                                                                                              |                                                                                                                                                                                                                                                                                                                           |
| <b>Retail – 30 day supply- IU Health Pharmacies</b>                                                                             |                                                                                                                                                                                                                                                                                                                           |
| Tier 1 (Preferred Generic)                                                                                                      | \$3 Copayment per Prescription Order                                                                                                                                                                                                                                                                                      |
| Tier 2 (Non-Preferred Generic)                                                                                                  | \$10 Copayment per Prescription Order                                                                                                                                                                                                                                                                                     |
| Tier 3 (Preferred Brand Name)                                                                                                   | \$20 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                                                                                                                                                                                                                                                                                                 |
| <b>Retail – 30 day supply- CVS Caremark Advanced Choice Pharmacies</b>                                                          |                                                                                                                                                                                                                                                                                                                           |
| 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                                                                                                                                                                                                                                                                                                 |

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Schedule of Benefits (continued)

| Benefit                                                                                                              | Tier 1 Benefits<br>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 - <i>limited to 1 exam per Enrollee per Year</i>                                                            | \$0 Enrollee Cost Sharing                                                                             |
| Eyeglass Lenses - <i>limited to 1 set of lenses per Enrollee per Year</i>                                            | \$0 Enrollee Cost Sharing                                                                             |
| Eyeglass Frames - <i>limited to 1 set of frames per Enrollee Per Year</i>                                            | \$0 Enrollee Cost Sharing for Provider designated frames                                              |
| Contact Lenses - <i>includes materials only, covered once per Enrollee Per Year in lieu of eyeglasses</i>            | \$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                      |