



Health Plans

[Group Legal Name]

IU Health Plans Gold 500 Plus

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 and Tier 2 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: [01/01/2025]

Plan Year: [01/01/2025] through [12/31/2025]

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

OUT-OF-POCKET MAXIMUM (([Per Calendar Year][Per Plan Year])		
Family Status	Tier 1	Tier 2
Per Enrollee	\$9,100	\$18,200
Per Family	\$18,200	\$36,400

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 Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
Ambulance Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Behavioral Health Services		
Outpatient Services	\$15 Copayment	35% Coinsurance after Deductible
Inpatient Services	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	\$15 Copayment	35% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Deductible	35% Coinsurance after Deductible
Dental Services for Accidental Injury	30% Coinsurance after Deductible	50% 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>	<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	50% Coinsurance after Deductible
Radiology Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
Emergency Services		
Emergency Room - Cost	\$300 Copayment (waived if admitted); Benefit is subject to the Deductible after Copayment	\$300 Copayment (waived if admitted); Benefit is subject to the Deductible after Copayment
Urgent Care Center Services	\$60 Copayment	\$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	50% 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	50% Coinsurance after Deductible
Hospice Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Services		
Inpatient Facility Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Physician and Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - <i>limited to a maximum of 60 days per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - <i>limited to a maximum of 90 days per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Maternity Services		
Prenatal and Postnatal Care	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Delivery and Inpatient Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
Medical Supplies, Durable Medical Equipment and Appliances		
Medical Supplies	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Durable Medical Equipment	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthetics	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Orthotic Devices	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services		
Outpatient Facility	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physician Visits		
Primary Care Physician	\$15 Copayment	35% Coinsurance after Deductible
Specialty Physician	\$60 Copayment	35% Coinsurance after Deductible
Mental/Behavioral Health and Substance Abuse Disorder Office Visits	\$15 Copayment	35% Coinsurance after Deductible
Preventive Care Services	\$0 Enrollee Cost Sharing	\$0 Enrollee Cost Sharing
Surgical Services	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Telehealth Services		
Telehealth Visit	No Charge	Benefit cost sharing based on service type and rendering provider
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
Therapy Services – Outpatient Rehabilitative		
Physical Medicine Services - <i>limited to a maximum of 60 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Speech Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Occupational Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Manipulation Therapy - <i>limited to a maximum of 12 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitation Services		
Cardiac Rehabilitation - <i>limited to a maximum of 36 visits per Enrollee Per Year</i>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Pulmonary Rehabilitation - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	20% Coinsurance after Deductible	40% 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	50% Coinsurance after Deductible
Speech Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% Coinsurance after Deductible

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
Occupational Therapy - <i>limited to a maximum of 20 visits per Enrollee Per Year</i>	30% Coinsurance after Deductible	50% 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.	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	Not Applicable
Covered Transplant Procedure during the Transplant Benefit Period	<p>During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount.</p> <p>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.</p>	<p>During the Transplant Benefit Period, no Copayment/Coinsurance up to the Allowed Amount.</p> <p>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.</p>

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
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	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	50% 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	50% 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	Covered as determined by the Contract
Prescription Drugs		
<i>Retail – 30 day supply- IU Health Pharmacies</i>		
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	

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
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	
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	
Out of Network Pharmacies		
Out of Network	Not Covered	50% Coinsurance per Prescription Order after Deductible

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Schedule of Benefits (continued)

Benefit	Tier 1 Benefits Cost Sharing per Enrollee	Tier 2 Benefits Cost Sharing per Enrollee
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	Not Covered
Eyeglass Lenses - <i>limited to 1 set of lenses per Enrollee per Year</i>	\$0 Enrollee Cost Sharing	Not Covered
Eyeglass Frames - <i>limited to 1 set of frames per Enrollee Per Year</i>	\$0 Enrollee Cost Sharing for Provider designated frames	Not Covered
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	Not Covered
Conventional	One pair annually from selection of designated contact lenses	Not Covered
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Not Covered
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses	Not Covered