Health Plans

[Group Legal Name]

HSA 03003S (2025)

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: [ ]

Plan Year: [ ] through [ ]

DEDUCTIBLE ([Per Calendar Year][Per Plan Year])			
Family Status	**Tier 1 In-Network Benefits**	**Tier 2 In-Network Benefits**	**Tier 3 Out-of-Network Benefits**
Per Enrollee	**$2,000**	**$4,000**	**$8,000**
Per Family	**$4,000**	**$8,000**	**$16,000**

OUT-OF-POCKET MAXIMUM ([Per Calendar Year][Per Plan Year])			
Family Status	**Tier 1 In-Network Benefits**	**Tier 2 In-Network Benefits**	**Tier 3 Out-of-Network Benefits**
Per Enrollee	**$2,000**	**$6,550**	**$8,000**
Per Family	**$4,000**	**$9,200**	**$16,000**

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. Coverage for Health Care Services received from In-Network and Out-of-Network Providers will be covered only as provided in this Schedule of Benefits and the Evidence of Coverage.

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

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Ambulance Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Behavioral Health Services			
Outpatient Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Inpatient Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Outpatient Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Substance Abuse Disorder Inpatient Services	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Dental Services for Accidental Injury	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
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.	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.	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	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Radiology Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
X-ray Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Emergency Services			
Emergency Room - Cost	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Urgent Care Center Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Home Care Services			
Home Care Visits - *limited to a maximum of 100 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Private Nursing Visits - *limited to a maximum of 82 visits per Enrollee Per Year and 164 visits per Enrollee per lifetime*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospice Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Services			
Inpatient Facility Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Physician and Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Medicine and Day Rehabilitation - *limited to a maximum of 60 days per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Skilled Nursing Facility Services - *limited to a maximum of 90 days per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Schedule of Benefits (continued)

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Maternity Services			
Prenatal and Postnatal Care	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Delivery and Inpatient Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Medical Supplies, Durable Medical Equipment and Appliances			
Medical Supplies	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Durable Medical Equipment	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Prosthetics	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Orthotic Devices	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Services			
Outpatient Facility	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physician Visits			
Primary Care Physician	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Specialty Physician	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Mental/Behavioral Health and Substance Abuse Disorder Office Visits	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Preventive Care Services	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	50% Coinsurance after Deductible
Surgical Services	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Telehealth Services	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing
Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Therapy Services – Outpatient Rehabilitative			
Physical Medicine Services - *limited to a maximum of 60 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Manipulation Therapy - *limited to a maximum of 12 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Rehabilitation Services			
Cardiac Rehabilitation - *limited to a maximum of 36 visits per Enrollee Per Year*	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Pulmonary Rehabilitation - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	20% Coinsurance after Deductible	30% Coinsurance after Deductible
Therapy Services – Outpatient Habilitative			
Physical Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Speech Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible
Occupational Therapy - *limited to a maximum of 20 visits per Enrollee Per Year*	0% Coinsurance after Deductible	30% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services			
Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services: The Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services benefits or requirements described below do not apply to the following. • Cornea and kidney transplants, and • Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. The above Health Care Services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending on where the service is performed, subject to Cost Sharing.			
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.	No Coverage
Deductible	Not Applicable	Not Applicable	No Coverage

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network 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.	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.	No Coverage
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	No Coverage
Transportation and Lodging	0% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit	30% Coinsurance after Deductible Covered, as approved by the Contract, up to a $10,000 benefit limit	No Coverage
Unrelated Donor Searches for Bone Marrow/Stem Cell Transplants for a Covered Transplant Procedure	0% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit	30% Coinsurance after Deductible Covered, as approved by the Contract, up to a $30,000 benefit limit	No Coverage
Live Donor Health Services	Covered as determined by the Group Contract	Covered as determined by the Group Contract	No Coverage

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Prescription Drugs			
Retail – *30 day supply- IU Health Pharmacies*			
Tier 1 (Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 2 (Non-Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 3 (Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 4 (Non-Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 5 (Specialty)	0% Coinsurance to maximum of $350 per Prescription Order after Deductible	0% Coinsurance to maximum of $350 per Prescription Order after Deductible	No Coverage
Tier 6 (Preventive)	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	No Coverage
Retail – *30 day supply- CVS Caremark Advanced Choice Pharmacies*			
Tier 1 (Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 2 (Non-Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 3 (Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Tier 4 (Non-Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 5 (Specialty)	0% Coinsurance to maximum of $350 per Prescription Order after Deductible	0% Coinsurance to maximum of $350 per Prescription Order after Deductible	No Coverage
Tier 6 (Preventive)	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	No Coverage
Mail Order – *90 day supply*			
Tier 1 (Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 2 (Non-Preferred Generic)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 3 (Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 4 (Non-Preferred Brand Name)	0% Coinsurance per Prescription Order after Deductible	0% Coinsurance per Prescription Order after Deductible	No Coverage
Tier 5 (Specialty)	Limited to 30 Day Supplies	Limited to 30 Day Supplies	No Coverage
Tier 6 (Preventive)	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	No Coverage
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	$0 Enrollee Cost Sharing	No Coverage

Benefit	Tier 1 In-Network Benefits Cost Sharing per Enrollee	Tier 2 In-Network Benefits Cost Sharing per Enrollee	Tier 3 Out-of-Network Benefits Cost Sharing per Enrollee
Eyeglass Lenses - *limited to 1 set of lenses per Enrollee per Year*	$0 Enrollee Cost Sharing	$0 Enrollee Cost Sharing	No Coverage
Eyeglass Frames - *limited to 1 set of frames per Enrollee Per Year*	$0 Enrollee Cost Sharing for Provider designated frames	$0 Enrollee Cost Sharing for Provider designated frames	No Coverage
Contact Lenses - *includes materials only, covered once per Enrollee Per Year in lieu of eyeglasses*	$0 Enrollee Cost Sharing for designated contact lenses	$0 Enrollee Cost Sharing for designated contact lenses	No Coverage
Conventional	One pair annually from selection of designated contact lenses	One pair annually from selection of designated contact lenses	No Coverage
Extended Wear Disposables	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	Up to 6 month supply of monthly or 2 week disposable, single vision spherical or toric contact lenses	No Coverage
Daily Wear / Disposables	Up to 3 month supply of daily disposable, single vision spherical contact lenses	Up to 3 month supply of daily disposable, single vision spherical contact lenses	No Coverage