Indiana University Health

La Porte Hospital La Porte Physicians Starke Hospital Lakeshore Surgicare

2013 PREMIUM RATES

Pre-tax payroll deductions for medical, dental, and vision are taken bi-weekly for 26 pay periods. The premium rates shown here reflect the bi-weekly payroll deduction amounts.

MEDICAL COVERAGE **Encore Network:** **www.encoreconnect.com**			
MEDICAL PLAN A		**MEDICAL PLAN B (HSA)**	
Deductibles **$1,000 Individual** **$2,000 Employee + Spouse / Employee + 1 child** **$3,000 Family (3 or more)**		**Deductibles** **$2,500 Individual** **$5,000 Family (2 or more)**	
Employee Only	$60.00	Employee Only	$20.00
Employee + Spouse	$120.00	Employee + Spouse	$32.00
Employee + Child(ren)	$96.00	Employee + Child(ren)	$30.00
Employee + Family	$192.00	Employee + Family	$37.00

Health Savings Account (HSA): To be eligible for a Health Savings Account you must be covered by an HSA-Qualified High Deductible Health Plan (HDHP) and MUST NOT be covered by other health insurance that is not a HDHP. The Medical Plan B Option, under the IU Health La Porte Hospital Medical Plan is a qualified health plan that meets the criteria for an HSA.

IU Health La Porte Hospital will support your HSA by contributing $750 for an individual or $1,500 for family (annually, funded on a per pay basis).

DENTAL COVERAGE		**VISION COVERAGE**	
NOTE: Dental and Vision coverage do not require selection of Provider Network.			
Employee Only	$6.73	Employee Only	$2.42
Employee + Family	$12.43	Employee + Family	$3.81

Summary of Benefits – MEDICAL PLAN A	IU Health La Porte Hospital/Starke Hospital/Lakeshore Surgicare	Encore PPO	Out-of-Network
Annual Deductible			
Per Employee Per Employee + Spouse OR Employee+ Child(ren) Per Family (3 or more)	$1,000 $2,000 $3,000	$1,000 $2,000 $3,000	$2,000 $4,000 $6,000
Annual Out-of-Pocket Maximum per calendar year (NOT including deductible)			
Per Employee Per Employee + Spouse OR Employee+ Child(ren) Per Family (3 or more)	$4,000 $8,000 $12,000	$4,000 $8,000 $12,000	$8,000 $16,000 $24,000
HOSPITAL SERVICES*			
• Emergency (serious medical condition requiring immediate care and treatment to avoid jeopardy to the life and health of individual) paid after deductible.	100%	90%	90%
• Non-Emergent use of ED (paid after deductible)	80%	70%	50%
• Inpatient (paid after deductible)	100%	80%	60%
• Outpatient, including x-ray and laboratory services (paid after deductible) NOTE: Lab services performed at an IU Health La Porte Physicians Office will be covered 100%	100%	80%	60%
• Mental Health and Substance Abuse (paid after deductible)	100%	80%	60%
*Any additional charges billed with IU Health La Porte Hospital/Starke Hospital/Lakeshore Surgicare TAX ID, after deductible, will be paid at 100%			
PHYSICIAN SERVICES			
• All Physician charges for Inpatient, Outpatient & Non-Emergent visits (paid after deductible)	N/A	80%	60%
• Office Visits	N/A	Primary Care: $20 copay Specialist: $35 copay	60%
• Urgent Care	N/A	$40 copay	60%
WELLNESS BENEFIT/ROUTINE CARE			
• Services provided through Wellness Center program at IU Health La Porte Hospital/Starke Hospital o Paid by the Plan per calendar year o Refer to the following pages for detailed information	Plan A participants up to $150.00		
• Other Wellness/Routine Services	100%		

Summary of Benefits – MEDICAL PLAN B	IU Health La Porte Hospital/Starke Hospital/Lakeshore Surgicare	Encore PPO	Out-of-Network
Annual Deductible Per Employee Per Employee + Spouse OR Employee+ Child(ren) OR Family* *If 2 or more family members are covered, the full $5,000 deductible must be satisfied before benefit is paid.	 $2,500 $5,000	 $2,500 $5,000	 $5,000 $10,000
Annual Out-of-Pocket Maximum per calendar year (Including deductible) Per Employee Per Employee + Spouse OR Employee+ Child(ren) OR Family	 $5,000 $10,000	 $5,000 $10,000	 $10,000 $20,000
HOSPITAL SERVICES* • Emergency (serious medical condition requiring immediate care and treatment to avoid jeopardy to the life and health of individual) paid after deductible. • Non-Emergent use of ED (paid after deductible) • Inpatient (paid after deductible) • Outpatient, including x-ray and laboratory services (paid after deductible) NOTE: Lab services performed at an IU Health La Porte Physicians Office will be covered 100% • Mental Health and Substance Abuse (paid after deductible) *Any additional charges billed with IU Health La Porte Hospital/Starke Hospital/Lakeshore Surgicare TAX ID, after deductible, will be paid at 100%	 100% 80% 100% 100% 100%	 90% 70% 80% 80% 80%	 90% 50% 60% 60% 60%
PHYSICIAN SERVICES • All Physician charges for Inpatient, Outpatient & Non-Emergent visits (paid after deductible) • Office Visits (paid after deductible)	 N/A N/A	 80% 80%	 60% 60%
WELLNESS BENEFIT/ROUTINE CARE • Services provided through Wellness Center program at IU Health La Porte Hospital/Starke Hospital o Paid by the Plan per calendar year o Refer to the following pages for detailed information • Other Wellness/Routine Services	 Plan B participants up to $300.00 100%		

<table>
<tr><th>SUMMARY OF BENEFITS - PHARMACY</th><th colspan="2">Medical Plan A</th><th colspan="2">Medical Plan B</th></tr>
<tr><td></td><td>Preferred:
IUH Pharmacies &
Kroger Pharmacies</td><td>Non-Preferred:
Other Retail Pharmacy Chains</td><td>Preferred:
IUH Pharmacies &
Kroger Pharmacies</td><td>Non-Preferred:
Other Retail Pharmacy Chains</td></tr>
<tr><td>Tier 1* – Generic (preferred)</td><td>30-day: $10
90-day: $25

300+ generics
30-day: $4
90-day: $10</td><td>30-day: $15
90-day: N/A</td><td rowspan="4">20% of the prescription cost once the deductible is met

After deductible is met, any expenses apply toward the annual out-of-pocket maximum.</td><td rowspan="3">30% of the prescription cost once the deductible is met

After deductible is met, any expenses apply toward the annual out-of-pocket maximum.</td></tr>
<tr><td>Tier 2* – Brand (preferred); select generics</td><td>30-day: $30
90-day: $75</td><td>30-day: $36
90-day: N/A</td></tr>
<tr><td>Tier 3* – Brand (non-preferred) & generics (non-preferred)</td><td>30-day: 30%
($50 min and $100 max)

90-day: 30%
($150 min and $300 max)</td><td>30-day: 30%
($60 min and $120 max)

90-day: N/A</td></tr>
<tr><td>Tier 4* – Specialty, Biotechnology medications</td><td>30-day: 25% ($170 max)
90-day: N/A</td><td>30-day: 30% ($210 max)
90-day: N/A</td><td>N/A</td></tr>
<tr><td>Mail Order</td><td colspan="2">Yes; through IUH Mail Order
Same copays as above

N/A</td><td>Yes; through IUH Mail Order
Same cost as above</td><td>N/A</td></tr>
<tr><td>Preventive Medications</td><td colspan="2">Yes, $0 copay</td><td colspan="2">Yes; $0 copay</td></tr>
<tr><td>Out of Pocket Maximum</td><td colspan="2">Pharmacy Costs Only:

Single: $2,000
Family: $4,000

NOTE: This out-of-pocket is separate from the medical plan out-of-pocket. Once you meet this maximum out-of-pocket limit with prescription expenses, all pharmacy costs are covered at 100% for the remainder of the plan year.</td><td colspan="2">Pharmacy costs under this plan apply to your medical plan deductible. Once your deductible has been met, you will pay the coinsurance amount listed above, with expenses applying to your medical plan out-of-pocket maximum.

Once the out-of-pocket maximum has been met, pharmacy costs are covered at 100% for the remainder of the plan year.</td></tr>
<tr><td colspan="5">*For medication tier, please refer to the 2013 drug formulary posted at http://www.healthsmart.com/lrhs.aspx.</td></tr>
</table>

WELLNESS BENEFITS 2013

Deductible is waived for Wellness Claims

Section One

Claims with a "routine" diagnosis have no annual maximum.

☑ **PLANS A, B -** Covered 100%, no limit, each calendar year

Benefit Description:

- Bone Densimeter
- Diabetes Education
- Heart Cart and Heart & Vascular Screenings through the Heart & Vascular Center - self referral/registration required, call 219-326-2626
- Personal Health Screen - Wellness Center/The Crossing, call 326-2480
- If claim is submitted with "routine" diagnosis, the claim will be processed under the Wellness Benefit. Examples include, but are not limited to:
    - Annual Mammogram – 1 per calendar year
    - Annual Adult "Wellness/Routine" Physical Exam - 1 per calendar year
    - Well Child Exams – (infants and children)
    - Immunizations (adults and children)
    - Lab Work
    - Annual Pap Smear – 1 per calendar year

For more details, call HealthSmart at 1-800-687-4089

Section Two

Wellness dollars are available to each family member enrolled in the medical plan
(Employee, spouse, & dependents are eligible for this benefit)

Any expense in excess of the calendar year maximum will not be applied toward the plan's deductible, coinsurance provisions, or considered as a covered expense.

☑ **PLAN A -** Covered 100% up to $150 per cal/yr

☑ **PLAN B -** Covered 100% up to $300 per cal/yr

} Annual maximum benefit for section two

Benefit Description:

- Any program or service provided by IU Health La Porte or Starke Hospitals Wellness Program or IU Health Wellness Centers (excludes gift certificates and products)
- Weight Watchers
- Child Preparation classes*
- Safe Sitter®*
- YMCA Membership or a reputable fitness center of your choice (contact IU Health Human Resources for a list of participating YMCA's)

Performed by IU Health La Porte or Starke Hospitals Only

Summary of Benefit – DENTAL PLAN	**There are no networks under the Dental Plan so you may visit any provider you choose.**
Basic and Major Calendar Year Deductible	
Individual	$25
Family	$50
The deductible is waived for Diagnostic & Preventive Dental Services.	
Orthodontic Calendar Year Deductible	
Orthodontic services per individual	$50
Maximum Benefit Per Covered Person	
Preventive, Basic and Major services per calendar year (other than Orthodontics)	$1,200
Orthodontic services while covered by this *Plan (lifetime benefit per person)*	$1,200
Percentage of Customary and Reasonable Amount Payable For	
Diagnostic & Preventive Dental Services	100%
Basic Dental Services	80%
Major Dental Services	50%
Orthodontic Services	50%

Summary of Benefit – VISION PLAN	**There are no networks under the Vision Plan so you may visit any provider you choose.**
Examination/Maximum Benefit	$75
Limitation: One exam annually for employees, spouses, and dependent children	
Conventional Lenses and Frames/Maximum Benefit	
Single Vision/Pair	$40
Bi-focal/Pair	$60
Tri-focal/Pair	$80
Lenticular/Pair	$140
Frames	$100
Limitation: One pair during any 12 consecutive months for employees and covered spouses. One pair during any 12 consecutive months for dependent children.	
Contacts/Pair (In lieu of lenses and frames)	$120
Limitation: One pair of hard contacts or a year's supply of disposable contacts during any 12 Consecutive months for employees and covered spouses. One pair of hard contacts or a year's supply of disposable contacts during any 12 Consecutive months for dependent children.	
Vision benefit is limited to purchase of conventional lenses/frames OR contacts.	