The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit iuhealthplans.org or call 1-866-895-5828. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-895-5828 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: $750 Individual / $1,500 Family Tier 2: $1,500 Individual / $3,000 Family	If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of the deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1: $2,500 Individual / $5,000 Family Tier 2: $5,000 Individual / $10,000 Family	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments on certain services, Premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes, See iuhealthplans.org or call 1-866-895-5828 for a list of network providers.	You pay the least if you use a provider in the Tier 1 network. You pay more if you use a provider in the Tier 2 network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan bays (balance-billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Tier 1: $20 Copayment per visit Tier 2: $40 Copayment per visit	Not covered	None
	Specialist visit	Tier 1: $40 Copayment per visit Tier 2: $80 Copayment per visit	Not covered	None
	Preventive care/screening/ immunization	No Charge – Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. To determine if a service requires authorization, go to www.iuhealthplans.org
	Imaging (CT/PET scans, MRIs)	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. To determine if a service requires authorization, go to www.iuhealthplans.org
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.iuhealthplans.org	Preferred generic drugs (Tier 1)	$5 Copayment per Prescription order (30 day supply) $12.50 Copayment per Prescription Order (90 day supply)	Not covered	None
	Non-preferred generic drugs (Tier 2)	$10 Copayment per Prescription Order (30 day supply) $25 Copayment per Prescription Order (90 day supply)	Not covered	None
	Preferred brand drugs (Tier 3)	$30 Copayment per Prescription Order (30 day supply) $75 Copayment per Prescription Order (90 day supply)	Not covered	None
	Non-preferred brand drugs (Tier 4)	$60 Copayment per Prescription Order (30 day supply)	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		$150 Copayment per Prescription Order (90 day supply)		
	Specialty drugs (Tier 5)	20% Coinsurance to a $350 Maximum per Prescription Order (30 day supply) Not Covered (90 day supply)	Not covered	None
	Preventive drugs (Tier 6)	No Charge – Deductible does not apply	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
	Physician/surgeon fees	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
If you need immediate medical attention	Emergency room care	$350 Copayment per visit	$350 Copayment per visit	Subject to Deductible. Benefits will be paid at Tier 1 benefit, however member may be balance billed by out-of-network provider.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Subject to Deductible
	Urgent care	$75 Copayment per visit	$75 Copayment per visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
	Physician/surgeon fees	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Tier 1: $10 Copayment per visit Tier 2: $25 Copayment per visit	Not covered	None
	Inpatient services	Tier 1: 10% Coinsurance Tier 2: 25% Coinsurance	Not covered	Subject to Deductible
If you are pregnant	Office visits	Tier 1: $40 Copayment per visit Tier 2: $80 Copayment per visit	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
	Childbirth/delivery facility services	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
If you need help recovering or have other special health needs	Home health care	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. Limited to a maximum of 100 visits per enrollee per year.
	Rehabilitation services	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. Cardiac-limited to a maximum of 36 visits and Pulmonary-limited to maximum of 20 visits per enrollee per year. Other limits apply; please see your plan document.
	Habilitation services	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. To determine if a service requires authorization, go to iuhealthplans.org. Limited to a maximum of 20 visits per enrollee per year.
	Skilled nursing care	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible. Limited to a maximum of 90 days per enrollee per year.
	Durable medical equipment	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
	Hospice services	Tier 1: 20% Coinsurance Tier 2: 40% Coinsurance	Not covered	Subject to Deductible
If your child needs dental or eye care	Children's eye exam	No Charge – Deductible does not apply	Not covered	Limited to 1 exam per enrollee per year
	Children's glasses	No Charge – Deductible does not apply	Not covered	Limited to 1 set of frames per enrollee per year Contacts – Includes materials only, covered once per enrollee per year in lieu of eyeglasses
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Impacted Teeth
- Infertility Treatment
- Non-emergency care when traveling outside of U.S.
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Private-Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Indiana University Health Plans, 950 N. Meridian St. Suite 400, Indianapolis, IN 46204, Phone No. 866-895-5828, TTY: 800-743-3333 and the Indiana State Department of Insurance, 311 W. Washington St. Suite 300, Indianapolis, IN 46204, Phone No. 317-232-2395. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Indiana University Health Plans ATTN: Grievances, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204, 866-895-5828, TTY: 800-743-3333. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If coverage is insured, contact the Indiana State Department of Insurance at 311 W. Washington St. Suite 300, Indianapolis, IN 46204, Phone No. 317-232-2395. For Indiana University Health Plans member services call 866-895-5975.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866.895.5828

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866.895.5828

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 866.895.5828

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866.895.5828

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$750**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,610**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist copayment	**$40**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,550**

The plan would be responsible for the other costs of these EXAMPLE covered services.

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org

Discrimination is Against the Law
IU Health does not discriminate on the basis of race, color, religion, sex, sexual orientation, age, disability, genetic information, veteran status, national origin, gender identity and/or expression, marital status, or any other characteristic protected by federal, state or local law.

Indiana University Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact IU Health Plans Customer Service at 800-455-9776.

If you believe that Indiana University Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Indiana University Health Plans, 950 N. Meridian St., Suite 400, Indianapolis, IN 46204; 800-455-9776, TTY/TDD 711 or 800-743-3333; Fax 317-963-9801; IUHPlansCompliance@iuhealth.org. You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the IU Health Plans Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Ave., SW
Room 509F, HHH Building
Washington, DC 20201
T: 800-368-1019
T: 800-537-7967

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

IU Health Plans cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
IU Health Plans 遵守適用的聯邦民權法律規定，不因種族、膚色、民 族血統、年齡、殘障或性別而歧視任何 人.

*For more information about limitations and exceptions, see the plan or policy document at iuhealthplans.org