



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/](http://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 <a href="#">deductible</a> ?                                | \$500 Individual / \$1,000 Family                                                                                                          | If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of the <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes, <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                                | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                         | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,100 Individual / \$18,200 Family                                                                                                       | If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover                | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, See <a href="http://iuhealthplans.org">iuhealthplans.org</a> or call 1-866-895-5828 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No                                                                                                                                         | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

 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<br>(You will pay the least)                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                             |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>                                                                                                                             | Primary care visit to treat an injury or illness       | \$15 Copayment per visit                                                                                                | Not covered                                        | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | <a href="#">Specialist</a> visit                       | \$60 Copayment per visit                                                                                                | Not covered                                        | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | <a href="#">Preventive care/screening/Immunization</a> | \$0 Enrollee Cost Sharing                                                                                               | Not covered                                        | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                                 | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% Coinsurance                                                                                                         | Not covered                                        | Subject to Deductible. To determine if a service requires authorization, go to <a href="http://iuhealthplans.org">iuhealthplans.org</a>                                                                                     |
|                                                                                                                                                                                                           | Imaging (CT/PET scans, MRIs)                           | 30% Coinsurance                                                                                                         | Not covered                                        | Subject to Deductible. To determine if a service requires authorization, go to <a href="http://iuhealthplans.org">iuhealthplans.org</a>                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://iuhealthplans.org">iuhealthplans.org</a> | Preferred generic drugs (Tier 1)                       | Retail (30 Day): \$5 Copayment per Prescription Order<br>Mail Order (90 Day): \$12.50 Copayment per Prescription Order  | Not covered                                        | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | Non-preferred generic drugs (Tier 2)                   | Retail (30 Day): \$15 Copayment per Prescription Order<br>Mail Order (90 Day): \$37.50 Copayment per Prescription Order | Not covered                                        | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | Preferred brand drugs (Tier 3)                         | Retail (30 Day): \$35 Copayment per Prescription Order<br>Mail Order (90 Day): \$87.50 Copayment per Prescription Order | Not covered                                        | None                                                                                                                                                                                                                        |
|                                                                                                                                                                                                           | Non-preferred brand drugs (Tier 4)                     | Retail (30 Day): \$70 Copayment per Prescription Order<br>Mail Order (90 Day): \$175 Copayment per Prescription Order   | Not covered                                        | None                                                                                                                                                                                                                        |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                            |
|---------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                   |
|                                                                           | <a href="#">Specialty drugs</a> (Tier 5)         | Retail (30 Day): 35% Coinsurance to maximum of \$350 per Prescription Order<br>Mail Order (90 Day): Limited to 30 Day Supplies | Not covered                                        | Subject to Deductible                                                                                                                                             |
|                                                                           | Preventive drugs (Tier 6)                        | \$0 Enrollee Cost Sharing                                                                                                      | Not covered                                        | None                                                                                                                                                              |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 30% Coinsurance                                                                                                                | Not covered                                        | Subject to Deductible                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | 30% Coinsurance                                                                                                                | Not covered                                        | Subject to Deductible                                                                                                                                             |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$300 Copayment per visit (waived if admitted)                                                                                 | \$300 Copayment per visit (waived if admitted)     | Subject to Deductible. Benefits will be paid at Tier 1 benefit, however member may be <a href="#">balance billed</a> by <a href="#">out-of-network provider</a> . |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% Coinsurance                                                                                                                | 30% Coinsurance                                    | Subject to Deductible                                                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | \$60 Copayment per visit                                                                                                       | \$60 Copayment per visit                           | None                                                                                                                                                              |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% Coinsurance                                                                                                                | Not covered                                        | Subject to Deductible                                                                                                                                             |
|                                                                           | Physician/surgeon fees                           | 30% Coinsurance                                                                                                                | Not covered                                        | Subject to Deductible                                                                                                                                             |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$15 Copayment per visit                                                                                                       | Not covered                                        | None                                                                                                                                                              |
|                                                                           | Inpatient services                               | 20% Coinsurance                                                                                                                | Not covered                                        | Subject to Deductible                                                                                                                                             |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                             |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                    |
| If you are pregnant                                            | Office visits                             | \$60 Copayment per visit                     | Not covered                                        | None                                                                                                                                                                                               |
|                                                                | Childbirth/delivery professional services | 30% Coinsurance                              | Not covered                                        | Subject to Deductible                                                                                                                                                                              |
|                                                                | Childbirth/delivery facility services     | 30% Coinsurance                              | Not covered                                        | Subject to Deductible                                                                                                                                                                              |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 30% Coinsurance                              | Not covered                                        | Subject to Deductible. Limited to a maximum of 100 visits per enrollee per year.                                                                                                                   |
|                                                                | <a href="#">Rehabilitation services</a>   | 30% 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.           |
|                                                                | <a href="#">Habilitation services</a>     | 30% Coinsurance                              | Not covered                                        | Subject to Deductible. To determine if a service requires authorization, go to <a href="http://iuhealthplans.org">iuhealthplans.org</a> . Limited to a maximum of 20 visits per enrollee per year. |
|                                                                | <a href="#">Skilled nursing care</a>      | 30% Coinsurance                              | Not covered                                        | Subject to Deductible. Limited to a maximum of 90 days per enrollee per year.                                                                                                                      |
|                                                                | <a href="#">Durable medical equipment</a> | 30% Coinsurance                              | Not covered                                        | Subject to Deductible                                                                                                                                                                              |
|                                                                | <a href="#">Hospice services</a>          | 30% Coinsurance                              | Not covered                                        | Subject to Deductible                                                                                                                                                                              |
| If your child needs dental or eye care                         | Children's eye exam                       | \$0 Enrollee Cost Sharing                    | Not covered                                        | Limited to 1 exam per enrollee per year                                                                                                                                                            |
|                                                                | Children's glasses                        | \$0 Enrollee Cost Sharing                    | 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                                                                                                                                                                                               |

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

### 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](http://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](http://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](http://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](http://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](#).

### 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, kwijigo holne' 866.895.5828

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist</a> copayment                          | \$60  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

*Cost Sharing*

|                             |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$500   |
| <a href="#">Copayments</a>  | \$10    |
| <a href="#">Coinsurance</a> | \$3,600 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$4,170</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well- controlled condition)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist</a> copayment                          | \$60  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

*Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$500 |
| <a href="#">Copayments</a>  | \$400 |
| <a href="#">Coinsurance</a> | \$100 |

*What isn't covered*

|                      |      |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,020</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |       |
|-----------------------------------------------------------------|-------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$500 |
| ■ <a href="#">Specialist</a> copayment                          | \$60  |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%   |
| ■ Other <a href="#">coinsurance</a>                             | 30%   |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

*Cost Sharing*

|                             |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$500 |
| <a href="#">Copayments</a>  | \$500 |
| <a href="#">Coinsurance</a> | \$500 |

*What isn't covered*

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,500</b> |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



## **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](mailto: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](https://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](https://hhs.gov/ocr/office/file/index.html).

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