**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
**What is the overall deductible?** | IU Health/Aetna-$1,500/$3,000*  
Out-of-Network- $2,500/$5,000*  
(*individual/family)  
Deductible is reduced to $0 once HRA credit is applied for Salary Tier 1 team members if care is received at an IU Health/Aetna provider/facility. Does not apply to preventive care by an in-network provider/facility. All Copayments and Rx coinsurances do not accumulate toward the deductible. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**Are there services covered before you meet your deductible?** | Yes, Preventive Care is 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/)

**Are there other deductibles for specific services?** | No | You don't have to meet the deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | IU Health/Aetna- $3,750*/$7,500**  
Out-of-Network- $6,500*/$13,000**  
(*OOP limit is reduced to $2,500 for Salary Tier 1 team members enrolled in Individual coverage if care provided by IU Health or Aetna provider/facility  
(**individual/family)) | The out-of-pocket limit is the most you could pay in a year for covered services. 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?** | Penalties, premiums, balance billed charges are not covered. | 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 myiuhealthplans.com or call 866.895.5975 for a list of network providers. | You pay the least if you use a provider in Tier I. You pay more if you use a provider in Tier II. 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 pays (balance billing). Be aware that 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.

* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
Do you need a referral to see a specialist? | No | You can see the specialist you choose without a referral.

---

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>IU Health/Aetna- $25 Copayment</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>IU Health/Aetna $40 Copayment</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>IU Health/Aetna- 10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>IU Health/Aetna- 10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>Preferred $4 Copayment (30 day), $10 Copayment (90 day); Non-Preferred $10 Copayment (30 day), $25 Copayment (90 day)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$30 Copayment (30 day), $75 Copayment (90 day)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>30% Coinsurance ($50 minimum, $100 maximum) (30 day), 30% Coinsurance ($150 minimum, $300 maximum) (90 day)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>25% Coinsurance ($75 minimum, $250 maximum) (30 day), Not Covered (90 day)</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>IU Health/Aetna- 10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>IU Health/Aetna- 10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>10% Coinsurance</td>
<td>10% Coinsurance</td>
</tr>
</tbody>
</table>

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

---

* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% Coinsurance</td>
<td>10% Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 Copayment</td>
<td>$25 Copayment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., hospital room)</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>IU Health/Aetna-$40 Copayment</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>IU Health/ Aetna- 10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>IU Health/Aetna-$40 Copayment</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>IU Health/Aetna-10% Coinsurance</td>
<td>50% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children's eye exam</td>
<td>$35 Copayment</td>
<td>$50 allowance</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>35% Discount</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**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
- Cosmetic surgery
- Dental Care
- Hearing Aids
- Habilitation services
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the US
- Private duty Nursing (rendered in a hospital or skilled nursing facility)
- 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.):**

- Bariatric surgery
- Chiropractic care
- Refractive eye exam

---

**Your Rights to Continue Coverage:** Here are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the insurer at 866.895.5975. You may also contact your state insurance department at: 311 W. Washington St., Suite 300, Indianapolis, IN 46204, Phone No. (317) 232-2385. 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 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: Allison Shelton, Civil Rights Coordinator, Indiana University Health Plans, 950 N Meridian St, Suite 400, Indianapolis, IN 46204, (317) 963-9788, TTY: (800) 743-3333, Fax (317) 963-9801, ashelton@iuhealth.org.

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

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 866.895.5975
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 866.895.5975
- Chinese (中文): 如果需要中文的帮助，请拨打这个号码 866.895.5975
- Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwiijig hołne’ 866.895.5975

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* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
**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**: $1,500
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $12,731

In this example, **Peg would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$86</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,240</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $2,886

---

### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible**: $1,500
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $7,389

In this example, **Joe would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$949</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$186</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $55

**The total Joe would pay is**: $2,690

---

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

- **The plan's overall deductible**: $1,500
- **Specialist copayment**: $40
- **Hospital (facility) coinsurance**: 10%
- **Other coinsurance**: 10%

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**: $1,925

In this example, **Mia would pay**:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,469</td>
</tr>
<tr>
<td>Copayments</td>
<td>$120</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$163</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $1,752

---

The **plan** would be responsible for the other costs of these **EXAMPLE** covered services.
**Discrimination is Against the Law**

Indiana University Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Indiana University Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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 Allison Shelton.

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: Allison Shelton, Civil Rights Coordinator, Indiana University Health Plans, 950 N Meridian St, Suite 400, Indianapolis, IN 46204, (317) 963-9788, TTY: (800) 743-3333, Fax (317) 963-9801, ashelton@iuhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Allison Shelton, 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 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
Language Assistance Services

English: ATTENTION: Our Member Services department has free language interpreter services available for non-English speakers. Call 866.895.5975 (TTY: 800.743.3333)


Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 866.895.5975（TTY: 800.743.3333）。

Burmese:

* For more information about limitations and exceptions, see the plan or policy document at myiuhealthplans.com
**Pennsylvania Dutch:** Wann du [Deitsch (Pennsylvania German / Dutch)] schwetscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 866.895.5975 TDD/TTY 800.743.3333 uffrufe.

**Arabic:**
ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. اتصل برقم 866.895.5975 (رقم هاتف الصم والصم: 800.743.3333).

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मु त में भाषा सहायता सेवाएं उपलब्ध हैं। 866.895.5975 (TTY: 800.743.3333) पर कॉल करें।

**Dutch:** Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 866.895.5975 (TDD/TTY 800.743.3333).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866.895.5975 (телетайп: 800.743.3333).

**Japanese:** 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。866.895.5975 (TTY: 800.743.3333) まで、お電話にてご連絡ください。

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