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 **myiuhealthplans.com** or call 866.895.5975. 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.cciio.cms.gov or call 866.895.5975 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	IU Health/Community-$1,500/$3,000* Encore/Aetna-$2,000/$4,000* Out-of-Network- $2,500/$5,000* (*individual/family) For non-Single coverage, the entire family deductible must be satisfied before the plan begins to pay for covered services. Deductible does not apply to preventive care services provided by an in network provider/ facility.	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/
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/Community- $3,750*/$7,500** Encore/Aetna- $5,500/$11,000** 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 is provided by an IU Health or Community provider or facility (**individual/family) For non-Single coverage, the entire family out-of-pocket limit must be met before the plan pays 100% of covered expenses.	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.

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

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.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Specialist visit	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Preventive care/screening/ immunization	No Charge	50% Coinsurance	Coinsurance subject to Deductible.
If you have a test	Diagnostic test (x-ray, blood work)	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Imaging (CT/PET scans, MRIs)	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.

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

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myiuhealthplans.com	Generic drugs	20% Coinsurance (30 and 90 day)	30% Coinsurance (30 day) Not Covered (90 day)	Subject to Deductible. Coverage limited to IU Health retail pharmacies only for 90 day supplies and mail order. This limitation does not apply to IU Health Morgan, IU Health Southern Indiana Physicians, and IU Health Paoli, Tipton and White Memorial Hospital team members.
	Preferred brand drugs	20% Coinsurance (30 and 90 day)	30% Coinsurance (30 day) Not Covered (90 day)	
	Non-preferred brand drugs	20% Coinsurance (30 and 90 day)	30% Coinsurance (30 day) Not Covered (90 day)	
	Specialty drugs	20% Coinsurance (30 day) and Not Covered (90 day)	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Physician/surgeon fees	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	Subject to Deductible. No coverage for non-emergent services provided in the ER.
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	Subject to Deductible.
	Urgent care	10% Coinsurance	10% Coinsurance	Subject to Deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.
	Physician/surgeon fees	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required for partial hospitalization.
	Inpatient services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.
If you are pregnant	Office visits	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Childbirth/delivery professional services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Childbirth/delivery facility services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
If you need help recovering or have other special health needs	Home health care	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible.
	Rehabilitation services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. 60 visit limit combined Occupational Therapy/Physical Therapy and separate 20 visit limit for Speech Therapy. Preauthorization required if done in home.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	IU Health/Community- 10% Coinsurance Encore/ Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.
	Durable medical equipment	IU Health/Community- 10% Coinsurance Encore/ Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required when cost is >$500.

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

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)	
	Hospice services	IU Health/Community- 10% Coinsurance Encore/Aetna- 30% Coinsurance	50% Coinsurance	Subject to Deductible. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	$35 Copayment	$50 allowance	Coverage limited to EyeMed Insight or IU Health contracted provider for in-network coverage.
	Children's glasses	35% Discount	Not Covered	Coverage is limited to EyeMed Insight network providers
	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
- 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.

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

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, kwiijigo holne' 866.895.5975

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

* 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 *coinsurance*	10%
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:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,267
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,827

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 *coinsurance*	10%
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:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$1,144
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,699

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

The plan's overall deductible	$1,500
Specialist *coinsurance*	10%
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:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,693

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)

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

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)

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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:

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက်
စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 866.895.5975 (TTY: 800.743.3333) သို့ ခေါ်ဆိုပါ။

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa 866.895.5975 (TTY: 800.743.3333).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 866.895.5975 (ATS : 800.743.3333).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 866.895.5975 (TTY: 800.743.3333).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 866.895.5975 (TTY: 800.743.3333).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866.895.5975 (TTY: 800.743.3333)번으로 전화해 주십시오.

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

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

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 866.895.5975 (رقم هاتف الصم والبكم: 800.743.3333).

Hindi: ध्यान दें: यदि आप हि दी बोलते हैं तो आपके लिए मु त में भाषा सहायता सेवाए उपलबध हैं। 866.895.5975 (TTY: 800.743.3333) पर कॉल करें।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, 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.

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

Punjabi: ਧਿਆਨ ਧਯਞਿੇ ਤੁਸੀਂ ੰਜਾਬੀ ਬੋਲਿ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਿ ਲਬ ਹੈ। 866.895.5975(TTY: 800.743.3333) 'ਤ ਕਾਲ ਕਰੋ।

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。

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