**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For

**Covered Services:** IU Health Plans: IU Health Employee Plan HSA Saver Medical Plan

**Northern Region**

**Coverage Period:** 1/1/2019-12/31/2019

**Coverage for:** EO, EC, ES, FA | **Plan Type:** HSA

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**Important Questions** | **Answers** | **Why This Matters:**
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**What is the overall deductible?** | IU Health/Encore-$2,500/$5,000*  
First Health-$3,000/$6,000*  
Out-of-Network- $3,500/$7,000*  
(*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 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/](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/Encore- $4,250*/$8,500**  
First Health- $6,250*/$12,500**  
Out-of-Network- $7,500*/$15,000**  
*OOP limit is reduced to $3,000 for Salary Tier 1 team members enrolled in Individual coverage if service provided at an IU Health or Encore provider/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.  

**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.  

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*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>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>IU Health/Encore - 20% Coinsurance First Health - 40% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Subject to Deductible.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>IU Health/Encore - 20% Coinsurance First Health - 40% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Subject to Deductible.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>60% Coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>IU Health/Encore - 20% Coinsurance First Health - 40% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Subject to Deductible.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>IU Health/Encore - 20% Coinsurance First Health - 40% Coinsurance</td>
<td>60% Coinsurance</td>
<td>Subject to Deductible. Preauthorization required.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% Coinsurance (30 and 90 day)</td>
<td>Subject to Deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% Coinsurance (30 and 90 day)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% Coinsurance (30 and 90 day)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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### Table of Common Medical Events and 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><strong>Coverage</strong> is available at <a href="http://www.myiuhealthplans.com">www.myiuhealthplans.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Specialty drugs</td>
<td>Network Provider (You will pay the least): IU Health/Encore- 20% Coinsurance, First Health- 40% Coinsurance</td>
<td>Subject to Deductible.</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Out-of-Network Provider (You will pay the most): 60% Coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>20% Coinsurance</td>
<td>Subject to Deductible. No coverage for non-emergent services provided in the ER.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% Coinsurance</td>
<td>Subject to Deductible.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>IU Health/Encore- 20% Coinsurance, First Health- 40% Coinsurance</td>
<td>Subject to Deductible. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>60% Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>IU Health/Encore- 20% Coinsurance, First Health- 40% Coinsurance</td>
<td>Subject to Deductible. Preauthorization required for partial hospitalization.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>60% Coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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<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>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Home health care</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% 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/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>IU Health/Encore- 20% Coinsurance</td>
<td>First Health- 40% Coinsurance</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$35 Copayment</td>
<td>$50 allowance</td>
</tr>
</tbody>
</table>

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### 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

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

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

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 20%
- **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**: $12,731

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

<table>
<thead>
<tr>
<th>Cost Sharing</th>
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<tbody>
<tr>
<td>Deductibles</td>
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<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $4,310

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

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 20%
- **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**: $7,389

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

<table>
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<tr>
<td>Copayments</td>
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<tr>
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</tr>
</tbody>
</table>

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

**The total Joe would pay is**: $3,992

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

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 20%
- **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**: $1,925

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

<table>
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</tr>
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</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $1,925
**Discrimination is Against the Law**

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  - 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

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Burmese: 866.895.5975 (TTY: 800.743.3333)


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