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.healthcare.gov/sbc-glossary or call 866.895.5975 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: IU Health/Community-$750/$1,500* Tier 2: Encore Combined/Aetna- $1,500/$3,000* Out-of-Network- $1,500/$3,000* (*individual/family) Deductible is eliminated to $0 for PCG-A team members if care is received at an IU Health/ Community 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 the deductible expenses paid by all family members meets the overall family deductible
Are there services covered before you meet your deductible?	Yes, Preventive Care 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?	Tier 1: IU Health/Community- $3,750/$7,500** Tier 2: Encore Combined/Aetna- $6,000/$12,000** Out of Network- $7,000/ $14,000** *OOP limit is reduced to $2,500 for PCG-A team members enrolled in individual coverage if care provided by IU Health or Community 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

Important Questions	Answers	Why This Matters:
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 1. You pay more if you use a provider in Tier 2. 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- $25 Copayment per visit Encore Combined/Aetna- $35 Copayment per visit	60% Coinsurance	Coinsurance subject to Deductible.
	Specialist visit	IU Health/Community- $40 Copayment per visit Encore Combined/Aetna- $60 Copayment per visit	60% Coinsurance	Coinsurance subject to Deductible.
	Preventive care/screening/ immunization	No Charge – deductible does not apply	60% Coinsurance	Coinsurance Subject to Deductible. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. To determine if a service requires authorization, go to myiuhealthplans.com
	Imaging (CT/PET scans, MRIs)	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. To determine if a service requires authorization, go to 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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible.
	Physician/surgeon fees	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible.
If you need immediate medical attention	Emergency room care	$300 Copayment per visit		Copayment waived if admitted. No coverage for non-emergent services provided in the ER.
	Emergency medical transportation	No Charge		None
	Urgent care	$10 Copayment per visit		None
If you have a hospital stay	Facility fee (e.g., hospital room)	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. Preauthorization required.
	Physician/surgeon fees	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. Preauthorization required for partial hospitalization.
	Inpatient services	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% 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 are pregnant	Office visits	IU Health/Community – $40 Copayment per visit Encore Combined/Aetna – $60 Copayment per visit	60% Coinsurance	Coinsurance subject to Deductible.
	Childbirth/delivery professional services	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible.
	Childbirth/delivery facility services	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible.
If you need help recovering or have other special health needs	Home health care	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible.
	Rehabilitation services	IU Health/Community – $40 Copayment per visit Encore Combined/Aetna – $60 Copayment per visit	60% Coinsurance	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 – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. Preauthorization required.
	Durable medical equipment	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% Coinsurance	Subject to Deductible. Preauthorization required when cost is >$500.
	Hospice services	IU Health/Community – 20% Coinsurance Encore Combined/Aetna – 40% Coinsurance	60% 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 your child needs dental or eye care	Children's eye exam	$35 Copayment per visit	$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

Common Medical Event		Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
			Network Provider			
			IU Health Pharmacy	CVS/Kroger/Payless Pharmacy	Preferred Network*	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myiuhealthplans.com	30 Day Supply	Tier 1: Preferred Generic	$0	$4	$25	Prescription drug copays are per prescription order and are not subject to deductible. *For a complete list of Rx providers, visit www.myiuhealthplans.com **90-day supply coverage limited to IU Health retail pharmacies, IU Health mail order pharmacy and CVS mail order pharmacy.
		Tier 2: Generic Drugs	$5	$10	$25	
		Tier 3: Preferred Brand and Selected Generic	$20	$30	$50	
		Tier 4: Non-preferred Brands and Non-preferred Generics	20% of cost ($50 min & $100 max)	30% of cost ($50 min & $100 max)	50% of cost ($150 min & $300 max)	
		Tier 5: Specialty/Biotech	25% of cost ($75 min & $250 max)	N/A	N/A	
	90 Day Supply**	Tier 1: Preferred Generic	$0	$10	N/A	
		Tier 2: Generic Drugs	$10	$25		
		Tier 3: Preferred Brand and Selected Generic	$40	$75		
		Tier 4: Non-preferred Brands and Non-preferred Generics	20% of cost ($150 min & $300 max)	30% of cost ($150 min & $300 max)		
		Tier 5: Specialty/Biotech	N/A	N/A		

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

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

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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

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

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

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

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,210

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

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

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

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,100

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

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

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,260

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 walangbayad. 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.

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: धयान दंे: यदद आप द दी बोलते ैं तो आपके ललए मु त मंे भाषा स ायता सेवाए उपलबध ैं। 866.895.5975 (TTY: 800.743.3333) पर कॉल करंे।

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mitdie 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: ਿਧਆਨ ਧਯਫ਼ਿੇ ਤੁਸੀਂ ੰਜਾਬੀ ਬੋਿਲ ੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧ ਿੱ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਿਪ 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。