

IU Health Plans: Southern Indiana Physicians HSA Medical Saver Plan Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: EO, EC, ES, FA | Plan Type: HSA



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myiuhealthplans.com or by calling 1.800.873.2022.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall <u>deductible</u> ? | SIHO \$2,000/\$4,000* ; Encore and PHCS \$2,500/\$5,000* ; Out-of-Network \$3,000/\$6,000* (*individual/family). For non-Single coverage, the entire family deductible must be satisfied before the plan begins to pay for covered services. Does not apply to preventive care. Rx coinsurances do not accumulate toward the deductible. | You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> |
| Are there other <u>deductibles</u> for specific services? | No | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes. SIHO \$4,250/\$8,500* ; Encore and PHCS \$6,250/\$12,500* ; Out-of-Network \$7,500 /\$15,000* (*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 <u>out-of-pocket limit</u> is the most you could pay for Covered Services, as designated by the plan, during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> ; health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |
| Is there an overall annual limit on what the plan pays? | No | The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u> ? | Yes. For a list of in-network <u>providers</u> call 1.800.873.2022 or see www.myiuhealthplans.com | If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. See the chart starting on page 2 |

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| | | |
|---|-----|---|
| | | for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist ? | No | You can see the specialist you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about excluded services . |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider (Subject to deductible, unless otherwise stated) | Your Cost If You Use an Out-of-Network Provider (subject to deductible, unless otherwise stated) | Limitations & Exceptions |
|---|--|--|--|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |
| | Specialist visit | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |
| | Other practitioner office visit | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance for chiropractor | Coverage limited to one visit and 12 manipulations per calendar year |
| | Preventive care/screening / immunization | No charge | 60% coinsurance | Deductible waived |
| If you have a test | Diagnostic test (x-ray, | SIHO 20%/Encore and | 60% coinsurance | ---None--- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider (Subject to deductible, unless otherwise stated) | Your Cost If You Use an Out-of-Network Provider (subject to deductible, unless otherwise stated) | Limitations & Exceptions |
|---|--|---|---|--|
| | blood work) | PHCS 40% coinsurance | | |
| | Imaging (CT/PET scans, MRIs) | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization required</u> |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.myiuhealthplans.com | Tier 1 – Preferred Generic | 20% of the prescription cost once the deductible is met. (90-day and mail order available only at IU Health) | | Coverage limited to IU Health retail pharmacies for 90 day supplies and mail order. |
| | Tier 2 – Generic | | | |
| | Tier 3 – Preferred Brands and Selected Generics | | | |
| | Tier 4 – Non-preferred Brands and Non-preferred Generics | | | |
| | Tier 5 – Specialty/Biotech | | | Coverage limited to 30-day supply at IU Health retail and Kroger pharmacy; no mail order |
| | Mail Order | Yes; through IUH Mail Order, same coinsurance as above | | |
| | Preventive Medications | Yes, \$0 Copay | | |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider (Subject to deductible, unless otherwise stated) | Your Cost If You Use an Out-of-Network Provider (subject to deductible, unless otherwise stated) | Limitations & Exceptions |
|--|---|---|---|--|
| | Pharmacy Copays Toward Plan Deductible | Yes; Individual \$2,000; Family \$4,000 | | |
| | Pharmacy Copays toward Max-out-of-pocket (MOOP) | Yes; Individual \$4,250; Family \$8,500 | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |
| | Physician/surgeon fees | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |
| If you need immediate medical attention | Emergency room services | SIHO 20%/Encore and PHCS 20% coinsurance | 20% coinsurance | No coverage for non-emergent services provided in the ER |
| | <u>Emergency medical transportation</u> | SIHO 20%/Encore and PHCS 20% coinsurance | 20% coinsurance | ---None--- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider (Subject to deductible, unless otherwise stated) | Your Cost If You Use an Out-of-Network Provider (subject to deductible, unless otherwise stated) | Limitations & Exceptions |
|--|--|--|--|---|
| | <u>Urgent care</u> | SIHO 20%/Encore and PHCS 20% coinsurance | 20% coinsurance | ---None--- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required |
| | Physician/surgeon fee | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required for partial <u>hospitalization</u> |
| | Mental/Behavioral health inpatient services | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required |
| | Substance use disorder outpatient services | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required for partial <u>hospitalization</u> |
| | Substance use disorder inpatient services | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | <u>Preauthorization</u> required |
| If you are pregnant | Prenatal and postnatal care | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |
| | Delivery and all inpatient services | SIHO 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | ---None--- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider (Subject to deductible, unless otherwise stated) | Your Cost If You Use an Out-of-Network Provider (subject to deductible, unless otherwise stated) | Limitations & Exceptions |
|---|----------------------------------|---|---|--|
| If you need help recovering or have other special health needs | <u>Home health care</u> | IU Health 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | Preauthorization required |
| | <u>Rehabilitation services</u> | IU Health 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | 60 visit limit combined Occupational Therapy/Physical Therapy and separate 20 visit limit for Speech Therapy Preauthorization is required if done in home. |
| | <u>Habilitation services</u> | Not covered | Not covered | |
| | <u>Skilled nursing care</u> | IU Health 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | Preauthorization required |
| | <u>Durable medical equipment</u> | IU Health 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | Preauthorization required when cost is > \$500 |
| | <u>Hospice service</u> | IU Health 20%/Encore and PHCS 40% coinsurance | 60% coinsurance | Preauthorization required |
| If your child needs dental or eye care | Eye exam | \$35 copay | \$50 allowance | Coverage limited to EyeMed Insight or IU Health contracted provider for in-network coverage |
| | Glasses | 35% discount | Not covered | Coverage is limited to EyeMed Insight network providers |
| | Dental check-up | Not covered | Not covered | ---None--- |

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Habilitation Services
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty Nursing (rendered in a hospital or skilled nursing facility)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Refractive Eye Exam

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1.800.873.2022. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1.877.267.2323 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: IU Health Plans, ATTN: Appeals, 950 N. Meridian Street Suite 200, Indianapolis, IN 46204 - or call 1.800.873.2022 or contact the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform

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

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

- **Amount owed to providers: \$11,825**
- **Plan pays \$7,868**
- **Patient pays \$3,957**

Sample care costs:

| | |
|-------------------------------------|-----------------|
| Hospital charges (mother & baby) | \$6,000 |
| Routine obstetric care - Antepartum | \$1,200 |
| Physician Delivery | \$2,085 |
| Anesthesia | \$1,300 |
| Additional Services | \$800 |
| Prescriptions | \$200 |
| Postnatal Care | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$11,825 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$2,000 |
| Copays | \$0 |
| Coinsurance | \$1,957 |
| Limits or exclusions | \$0 |
| Total | \$3,957 |

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$2,670**
- **Patient pays \$2,730**

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|----------------|
| Deductibles | \$2,000 |
| Copays | \$0 |
| Coinsurance | \$650 |
| Limits or exclusions | \$80 |
| Total | \$2,730 |

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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