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 deductible?	SIHO **$1,500/$3,000***; Encore and PHCS **$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. Does not apply to preventive care. All Copayments and Rx coinsurance do not accumulate toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. SIHO **$3,750/$7,500***; Encore and PHCS **$5,500/$11,000***; Out-of-Network **$6,500 /$13,000*** (*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 **out-of-pocket limit** 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 out–of–pocket limit?	**Premiums**; health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
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 *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers** call 1.800.873.2022 or see www.myiuhealthplans.com	If you use an in-network doctor or other health care **provider**, 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 **provider** for

		some services. See the chart starting on page 2 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 6. 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**, **co-payments** 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 10%/Encore and PHCS 30% coinsurance	50% coinsurance	---None---
	Specialist visit	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	---None---
	Other practitioner office visit	SIHO 10%/Encore and PHCS 30% coinsurance for chiropractor	50% coinsurance for chiropractor	Coverage limited to one visit and 12 manipulations per calendar year
	Preventive care/screening / immunization	No charge	50% coinsurance	Deductible waived
If you have a test	Diagnostic test (x-ray, blood	SIHO 10%/Encore and	50% coinsurance	---None---

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
	work)	PHCS 30% coinsurance		
	Imaging (CT/PET scans, MRIs)	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization required**
If you need drugs to treat your illness or condition More information about **prescription drug coverage** 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		
	Pharmacy Copays Toward Plan Deductible	Yes; Individual $1,500; Family $3,000		

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 Max-out-of-pocket (MOOP)	Yes; Individual $3,750; Family $7,500		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	SIHO 10%/ Encore and PHCS 30% coinsurance	50% coinsurance	---None---
	Physician/surgeon fees	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	---None---
If you need immediate medical attention	Emergency room services	SIHO 10%/ Encore and PHCS 10% coinsurance	10% coinsurance	No coverage for non-emergent services provided in the ER
	Emergency medical transportation	SIHO 10% /Encore and PHCS 10% coinsurance	10% coinsurance	---None---
	Urgent care	SIHO 10% /Encore and PHCS 10% coinsurance	10% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
	Physician/surgeon fee	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required for partial **hospitalization**
	Mental/Behavioral health inpatient services	SIHO 10%/ Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
	Substance use disorder outpatient services	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required for partial **hospitalization**
	Substance use disorder inpatient services	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
If you are pregnant	Prenatal and postnatal care	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	---None---

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
	Delivery and all inpatient services	SIHO 10%/Encore and PHCS 30% coinsurance	50% coinsurance	---None---
If you need help recovering or have other special health needs	**Home health care**	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
	Rehabilitation services	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	60 visit limit combined Occupational Therapy/Physical Therapy and separate 20 visit limit for Speech Therapy Preauthorization is required if done in home.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
	Durable medical equipment	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required when cost is > $500
	Hospice service	SIHO 10% /Encore and PHCS 30% coinsurance	50% coinsurance	**Preauthorization** required
If your child needs dental or eye care	Eye exam	$35 co-pay	$50 allowance	Coverage limited to EyeMed Insight or SIHO 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---

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: SIHO 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.

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.

Having a baby

- **Amount owed to providers:** $11,825
- **Plan pays** $9,297
- **Patient pays** $2,528

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	$1,500
Co-pays	$0
Coinsurance	$1,028
Limits or exclusions	$0
Total	**$2,528**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,210
- **Patient pays** $2,190

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	$1,500
Co-pays	$0
Coinsurance	$610
Limits or exclusions	$80
Total	**$2,190**

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.