**Health Savings Account - Nyhart Company**

| Annual IU Contribution to Health Savings Account | • $1,600 for employee-only coverage  
• $3,200 when one or more family members are covered (all other coverage levels) |
| Annual Employee Contribution to Health Savings Account | • $300 minimum |
| Annual IRS Maximum Contributions  
(maximums are combined IU and employee contributions) | • $3,450 for employee-only coverage; $6,900 all other coverage levels.  
• Employees age 55 or older are allowed “catch-up” contributions up to an additional $1,000 annually |
| Health Savings Account Features | • Contributions, interest, and investment earnings can be used to pay for IRS-qualified medical expenses; account funds are generally not subject to federal, state, or FICA taxes.  
• Balances roll over year to year and stay with the employee even after leaving the university.  
• Balances of $1,000 or more may be placed in an array of investment options. |

**Medical Benefits - IU Health Plans Network**

IU Health Plans Network includes most Indiana counties. Visit [iuhealthplans.org](http://iuhealthplans.org) for a provider directory.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider – Member Pays1</th>
<th>Out-of-Network Provider – Member Pays3</th>
</tr>
</thead>
</table>
| Annual Deductible  
Applies to all medical and prescription services except wellness/preventive. | $2,500 for employee-only coverage  
$5,000 all other coverage levels |  |
| Covered Charges | Up to the Maximum Allowable Amount that In-Network providers accept as payment in full. |  |
| Medical Out-of-Pocket Maximum  
(All co-insurances and deductibles apply toward this maximum) | $3,000 for employee-only coverage  
$6,000 all other coverage levels |  |
| Physician Office Services  
• Primary care (PCP) visits/consultations  
• Specialist visits/consultations/therapy  
• High cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics, allergy testing | 20% coinsurance after deductible |  |
| Preventive Services  
• Office Services (e.g. routine exams, well child visits, immunizations, labs, hearing screenings)  
• Hospital/Alternative Facility Surgical Procedures (e.g. screening colonoscopy)  
• Non-surgical Hospital/Alternative Facility services (pap tests, mammograms, PSA, and other lab services)  
• Women’s contraceptive services such as IUDs, implanted and injectable hormones, and sterilization |  | No coverage except in an emergency3 |
| Hospital/Alternative Facility Surgical Procedure | 20% coinsurance after deductible |  |
| Hospital Inpatient Services | 20% coinsurance after deductible |  |
| Professional Services Provided during a Hospital Inpatient Stay or during an Outpatient/Alternative Facility Surgical Procedure | 20% coinsurance after deductible |  |
| Maternity Services | Covered as any other illness. Subject to same deductibles, coinsurance, and maximums. |  |
| Emergency Room for Emergency Care  
No coverage unless an emergency | 20% coinsurance after deductible | Paid as In-Network when emergency3 |
| Urgent Care Facility  
• Facility Visit  
• High cost diagnostics, pharmaceuticals, durable medical equipment/prosthetics, allergy testing | 20% coinsurance after deductible | Paid as In-Network when more than 50 miles from home |
| Other Outpatient Services  
• Non-surgical outpatient services (examples: MRIs, C-Scans, Chemotherapy, Ultrasounds, X-Rays, and other diagnostics)  
• Durable Medical Equipment (DME)  
• Home Care (Out-of-Network limited to 30 visits)  
• Outpatient Laboratory Services | 20% coinsurance after deductible | No coverage except in an emergency4 |

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1 In-Network and Out-of-Network deductible, coinsurance, and maximums are separate and do not accumulate toward each other.

2 Alternative Facilities include facilities (free standing/attached to a hospital) that are designated primarily for outpatient services like surgery, diagnostic testing (e.g. MRIs), or therapy/rehabilitation.

3 Primary and Urgent Care paid as In-Network for Out-of-State dependents.
### Medical Benefits (continued)

#### Outpatient Therapy Services
(Combined In- and Out-of-Network limits apply)
- Physician Home and Office Visits (PCP/SCP)
- Other Outpatient Services at Hospital/Alternative Facility

Limits apply to:
- Physical therapy (limited to 60 visits)
- Occupational therapy (limited to 60 visits)
- Manipulation therapy (limited to 12 visits)
- Speech therapy (limited to 20 visits)

<table>
<thead>
<tr>
<th></th>
<th>In-Network Provider – Member Pays</th>
<th>Out-of-Network Provider – Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% coinsurance after deductible</td>
<td>No Coverage</td>
<td></td>
</tr>
</tbody>
</table>

#### Precertification Requirements
Network providers are required to precertify all inpatient stays (except deliveries) and certain outpatient services, for example, high-cost procedures such as brain/spine MRIs, PET scans, and sleep studies. When a member receives services out-of-network, the member is responsible for precertifying services and any additional costs incurred by failure to precertify.

#### Mental Health & Substance Abuse
All services must be preauthorized by IU Health Plans.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider – Member Pays</th>
<th>Out-of-Network Provider – Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health &amp; Substance Abuse</td>
<td>Covered as any other illness; subject to same deductibles, coinsurances, and maximums. (Residential MH/SA covered as inpatient.)</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

#### Organ & Tissue Transplants

<table>
<thead>
<tr>
<th>Transplants</th>
<th>In-Network Provider – Member Pays</th>
<th>Out-of-Network Provider – Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Except kidney and cornea - covered as medical benefit.</td>
<td>20% after deductible</td>
<td>No Coverage</td>
</tr>
</tbody>
</table>

#### Outpatient Prescription Drugs - CVS Caremark
Benefits are subject to certain prior authorization and quantity limit guidelines. Certain diabetic and asthmatic supplies are covered in full but coverage is limited to network pharmacies only.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider – Member Pays</th>
<th>Out-of-Network Provider – Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Prescriptions (Up to 30-day supply or 90-day supply at CVS Pharmacies)</td>
<td>20% after deductible&lt;sup&gt;3&lt;/sup&gt; Specialty Drugs&lt;sup&gt;4&lt;/sup&gt; are not covered at Retail No coinsurance or deductible on most contraceptives.</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Mail Order Prescriptions (Up to 90-day supply) and Specialty Drugs&lt;sup&gt;4&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>3</sup> No deductible on preventive prescriptions. For drug list, visit [hr.iu.edu/benefits](http://hr.iu.edu/benefits).

<sup>4</sup> Specialty Drugs: High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.

#### EyeMed Vision
(See separate summary for benefit details)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network Provider – Member Pays</th>
<th>Out-of-Network Provider – Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam Annual comprehensive eye exam and refraction</td>
<td>$10 copay, no deductible</td>
<td>Costs above a $30 allowance</td>
</tr>
<tr>
<td>Vision Wear Contacts, frames, and lenses</td>
<td>Specific allowances and discounts. Highest level of benefit in-network. Some enhancements are not covered out-of-network. See the separate summary for benefit details.</td>
<td></td>
</tr>
</tbody>
</table>

#### Partial List of Exclusions
(Complete list in plan booklet)

- Acupuncture
- Cosmetic surgery, procedures, and drugs.
- Dental care (Adult)
- Hearing Aids (Adults age 18 or older)
- Infertility treatment
- Custodial care, convalescent, or “long-term” nursing care.
- Private duty nursing in a hospital or skilled nursing facility.
- Supportive devices for the feet, and routine foot care.
- Routine eye care except as covered in Vision Benefit.
- Any service not medically necessary as determined by the Plan Administrator.
- Services, supplies, and drugs for obesity or weight control, except surgery for morbid obesity.

This is a plan summary. The entire provisions of benefits and exclusions are contained in the Plan Booklet which can be obtained at [hr.iu.edu/benefits](http://hr.iu.edu/benefits). In the event of a conflict with this document, the terms of the Plan Booklet will prevail. For more information please visit [hr.iu.edu/benefits](http://hr.iu.edu/benefits).