HEALTH SAVINGS ACCOUNT—NYHART

Annual IRS Maximum Contribution to HSA
Max includes IU and employee contributions combined.

- $3,650 employee-only coverage
- $7,300 all other coverage levels

IU Annual Contribution to HSA

- $1,600 employee-only coverage
- $3,200 all other coverage levels

Employee Annual Contribution to HSA

- $300 minimum up to IRS maximum

MEDICAL BENEFITS—IU HEALTH PLANS NETWORK

Covered Charges: Up to the Maximum Allowable Amount that In-Network providers accept as payment in full.

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.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (Applies to all medical/prescription services except preventive)</td>
<td>$2,700 employee-only coverage $5,400 all other coverage levels</td>
<td>No coverage except in an emergency</td>
</tr>
<tr>
<td>Medical Out-of-Pocket Maximum (OOPM) (All coinsurances and deductibles apply to OOPM)</td>
<td>$3,400 employee-only coverage $6,800 all other coverage levels</td>
<td></td>
</tr>
<tr>
<td>Emergency Room for Emergency Medical Condition and Ambulance Services (when Medically Necessary)</td>
<td>20% after deductible No coverage unless an emergency.</td>
<td>Paid as in-network when emergency</td>
</tr>
</tbody>
</table>

Hearing Care
- Office visit–audiometric exam/hearing evaluation test
- Hearing Devices/Hearing Aids
  - Dependents under age 18 limit 1 per ear every 36 months
  - Adults age 18 and older maximum of $3,000 once every 5 years for one or both ears

Home Health Care Services
- Private Duty Nursing only covered in the home

20% after deductible

Hospital Care Services

Hospital Inpatient Services (Precertification required)
- Room and board (semiprivate or ICU/CCU)
- Hospital services & supplies (x-ray, lab, anesthesia, surgery (precertification required), etc.)
- Physician services (surgeon, anesthesiologist, etc.)

20% after deductible

Maternity Care

Covered as any other medical condition. Subject to same deductibles, coinsurance, and maximums.

Medical Supplies & Equipment
- Medical supplies
- Durable medical equipment (DME)
- Prosthetic appliances (external)

20% after deductible

Outpatient Hospital/Facility Services
- Outpatient facility
- Lab and x-ray services
- Physician services (surgeon, anesthesiologist, etc.)

20% after deductible

Physician Office Services
- Primary care (PCP) & Specialist visits/consultations
- Office surgery, online visits, diagnostic services, allergy testing & treatment
- Prescription injectables/prescriptions dispensed in physician’s office

20% after deductible

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1 Primary and urgent care paid as in-network for covered dependents of an Indiana-Resident employee when the dependent lives out of the state of Indiana for reasons other than medical treatment.
### Preventive Services
- **Office Services** (e.g., routine exams, well child visits, immunizations, labs, routine vision and hearing exams, pelvic exams, STI screenings)
- **Hospital/Facility Procedures** (e.g., screening colonoscopy, pap tests, mammograms, PSA test)
- **Women’s contraceptive services** (e.g., IUDs, implanted and injectable hormones, and sterilization)

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Covered at 100%—not subject to deductible</td>
<td></td>
<td>No coverage except in an emergency¹</td>
</tr>
</tbody>
</table>

### Therapy Services (Outpatient)
Combined in- and out-of-network limits apply to:
- Physical/Occupational/Speech Therapy: 140 visits combined
- manipulation Therapy: 12 visits
- Cardiac Rehabilitation: Unlimited
- Pulmonary Rehabilitation: Unlimited

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy Services (Outpatient)</td>
<td>20% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

### Urgent Care Clinic Visit

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Clinic Visit</td>
<td>20% after deductible</td>
<td>Paid as in-network when more than 50 miles from home¹</td>
</tr>
</tbody>
</table>

### Behavioral Health & Substance Use
Many services must be preauthorized by IU Health Plans.

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health &amp; Substance Use</td>
<td>Covered as any other medical condition. Subject to same deductibles, coinsurance, and maximums. Residential BH/SA covered as inpatient.</td>
<td>No coverage except in an emergency¹</td>
</tr>
</tbody>
</table>

### Human Organ & Tissue Transplants

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network—Member Pays</th>
<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplants</td>
<td>20% after deductible</td>
<td>No coverage except in an emergency¹</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 in-network pharmacies only.

<table>
<thead>
<tr>
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<th>Out-of-Network—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 deductible²</td>
<td>No coverage</td>
</tr>
<tr>
<td>Mail Order Prescriptions (Up to 90-day supply) Specialty Drugs² (Up to 30-day supply)</td>
<td>20% after deductible²</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

² No deductible on preventive prescriptions. For drug list, visit hr.iu.edu/benefits.

### Vision and Eyewear—EYEMED Vision
See separate summary for full benefit details.

<table>
<thead>
<tr>
<th>Service</th>
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<th>Out-of-Network—Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Eye Exam</td>
<td>$10 copay, no deductible</td>
<td>$42 allowance</td>
</tr>
<tr>
<td>Vision Wear</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 details.</td>
<td></td>
</tr>
</tbody>
</table>

### Partial List of Exclusions
See the plan booklet for a full list of exclusions.

- Acupuncture
- Cosmetic surgery, procedures, and drugs.
- Dental care (Adult)
- 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 are contained in the Plan Booklet which can be obtained at hr.iu.edu/benefits.

In the event of a conflict with this document, the terms of the Plan Booklet will prevail.