INDIANA UNIVERSITY

2021
PLAN YEAR

MEDICAL PLAN SUMMARY

IU Health HDHP & HSA

IU Health High Deductible Health Plan (HDHP) and Health Savings Account (HSA)

HEALTH SAVINGS ACCOUNT NYHART	
Annual IRS Maximum Contribution to HSA Max includes IU and employee contributions combined.	**$3,600** employee-only coverage **$7,200** all other coverage levels Employees age 55+ allowed a "catch up" contribution of up to an additional $1,000/year
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.

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Annual Deductible Applies to all medical/prescription services except preventive	**$2,700** employee-only coverage **$5,400** all other coverage levels	No coverage except in an emergency[1]
Medical Out-of-Pocket Maximum (OOPM) All coinsurances and deductibles apply to OOPM	**$3,400** employee-only coverage **$6,800** all other coverage levels	
Emergency Room for Emergency Medical Condition and Ambulance Services (when Medically Necessary)	**20%** after deductible No coverage unless an emergency.	Paid as in-network when emergency[1]
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	**20%** after deductible	No coverage except in an emergency[1]
Home Health Care Services • Private Duty Nursing only covered in the home	**20%** after deductible	
Hospice Care Services	**20%** after deductible	
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	

[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.*

Service	In-Network—Member Pays	Out-of-Network—Member Pays
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)	**$0** Covered at 100%—not subject to deductible	No coverage except in an emergency[1]
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	**20%** after deductible	
Urgent Care Clinic Visit	**20%** after deductible	Paid as in-network when more than 50 miles from home[1]

BEHAVIORAL HEALTH & SUBSTANCE USE
All services must be preauthorized by IU Health Plans.

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Behavioral Health & Substance Use	**Covered as any other medical condition**. Subject to same deductibles, coinsurance, and maximums. Residential BH/SA covered as inpatient.	No coverage except in an emergency[1]

HUMAN ORGAN & TISSUE TRANSPLANTS

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Transplants Except kidney and cornea (covered as medical benefit)	**20%** after deductible	No coverage except in an emergency[1]

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.

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Retail Prescriptions (Up to 30-day supply or 90-day supply at CVS Pharmacies)	**20%** after deductible[2] Specialty Drugs[3] are not covered at retail. No coinsurance or deductible on most contraceptives.	No coverage
Mail Order Prescriptions (Up to 90-day supply) **Specialty Drugs**[3] (Up to 30-day supply)		

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

[3] *Specialty Drugs: High cost, scientifically engineered drugs that are usually injected or infused. These drugs are only covered through mail order.*

VISION AND EYEWEAR EYEMED VISION
See separate summary for full benefit details.

Service	In-Network—Member Pays	Out-of-Network—Member Pays
Annual Eye Exam Annual comprehensive eye exam and refraction	**$10** copay, no deductible	**$42** allowance
Vision Wear Contacts, frames, and lenses	Specific allowances and discounts. Highest level of benefit in-network. Some enhancements are not covered out-of-network. See the separate summary for details.	

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.

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