2020 Pre-Medicare Benefits At-a-Glance

Benefits	Pre-Medicare University of Idaho Medical Plans		
	Plan A	**Plan A**	**Plan B**
	In-Network	**Out of Network**	**In- and Out-of-Network**
Annual Deductible for Medical Services and Supplies (you pay)			
Individual or Self-Only	$600	$900 per individual	$1,500
Family	$1,800		$3,000
Preventive Care & Wellness Services – for specifically listed services (plan pays) *For services not listed, you pay your deductible and cost-sharing amount.*	You pay nothing; Plan pays 100% of the maximum allowance	Not Covered	You pay nothing; Plan pays 100% of the maximum allowance for in-network services

Preventive Care & Wellness Services as required under ACA include, but are not limited to:

Adult Examinations – Annual physical examinations including Pap tests, fecal occult blood test, PSA tests, cholesterol panel, chemistry panel, diabetes screening, urinalysis, complete blood count, bone density, tuberculosis skin or tine test, thyroid stimulating test, uric acid, GGT (liver function test), screening EKG, preventive screening mammogram, colorectal cancer screening, one routine wellness hearing exam per year, thyroid stimulating hormone, transmittable disease screening (Chlamydia, Gonorrhea, HIV, Syphilis, Tuberculosis), aortic aneurysm ultrasound, alcohol misuse assessment, genetic counseling for high-risk family history of breast or ovarian cancer, health risk assessment for depression, lipid disorder screening, smoking and tobacco use tobacco cessation counseling visit, dietary counseling (up to three visits per year), urinary incontinence screening.

Women's Preventive Care Services – Coverage for additional preventive services including; breast-feeding support, supplies and counseling, contraception methods and counseling, domestic violence screening, gestational diabetes screening, HIV screening and counseling, Human Papillomavirus testing (beginning at age 30, and every 3 years thereafter), sexually transmitted infections counseling, and well-women visits.

Well-Baby Care and Well-Child Care – Routine or scheduled well-baby and well-child examinations, including rubella, thyroxine, sickle cell and PKU tests, newborn hearing test and screening examinations for sports physicals.

Maternity Benefits – Urine culture, hepatitis B virus screening, iron deficiency screening, Rh (D) incompatibility screening.

Immunizations and Travel Vaccines – Accellular pertussis, cholera, diphtheria, hemophilus, influenza B, hepatitis A, hepatitis B, human papilloma virus (HPV), influenza, H1N1, Japanese encephalitis, measles, meningococcal, mumps, plague, pneumococcal (pneumonia), poliomyelitis (polio), rotavirus, rubella, tetanus, typhoid, typhim VI, typhus, varicella (chicken pox), yellow fever and zoster.

Annual Medical Cost-Share Maximum Once the deductible is satisfied, cost sharing is paid until the cost-share maximum is satisfied, then the plan pays 100% of covered services.			
Individual or Self-Only	$3,850	$5,600 per individual	$3,100
Family	$11,550		$6,200
Lifetime Benefit Maximum	Unlimited		

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Ambulance Transportation Services (Ground or Air) (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Behavioral Health - Inpatient Services (you pay)	20% of the maximum allowance, after the annual deductible, and $100 per day copayment up to three (3) days per year per person	35% of the maximum allowance, after the annual deductible, and $100 per day copayment up to three (3) days per year per person	30% of the maximum allowance, after the annual deductible
Behavioral Health - Outpatient Psychotherapy Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Behavioral Health - Outpatient Applied Behavioral Analysis (ABA) (you pay) *(as part of an approved treatment plan)*	$35 copayment per visit, not subject to the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Behavioral Health - Treatment for Autism Spectrum Disorder (you pay) *(Services identified as part of the approved treatment plan)*	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to treatments for Autism Spectrum Disorder.	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to treatments for Autism Spectrum Disorder.	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of this table. Visit limits do not apply to treatments for Autism Spectrum Disorder.
Behavioral Health - Facility & Other Professional Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Blood Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Colonoscopy & Sigmoidoscopy Preventive Screen	You pay nothing; plan pays 100% of the maximum allowance	Not Covered	**In-network**: you pay nothing; plan pays 100% of the maximum allowance **Out-of-network: not covered**
Bariatric Surgery (requires prior authorization) (you pay)	Separate $1,500 deductible, then 20% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross of Idaho Center of Excellence Provider Only)	Not Covered	**In-network**: Separate $1,500 deductible, then 30% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross of Idaho Center of Excellence Provider Only) **Out-of-network: not covered**
Diagnostic Services related to Bariatric Surgery (you pay)	20% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross of Idaho Center of Excellence Provider Only)	Not Covered	**In-network**: 30% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross of Idaho Center of Excellence Provider Only) **Out-of-network: Not covered**
Contraceptive Services Birth Control Pills	See Prescription Drug Benefits for more information		
Contraceptive Services Diaphragms & IUD Depo Provera Injections (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible

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Dental Services related to Accidental Injury (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Diabetes Self-Management Education (you pay)	20% of the maximum allowance, after the annual deductible	Not Covered	**In-network**: 30% of the maximum allowance, after the annual deductible **Out-of-network: Not covered**
Diagnostic Services (you pay) *Excluding eligible wellness & preventive care services)*	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Durable Medical Equipment, Prosthetics & Orthotics (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Emergency Room Copay (you pay)	$100 copay per visit	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
All Other Emergency Services (you pay) ***You may be balance-billed for out-of-network emergency services.***	20% of the maximum allowance, after the annual deductible	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Hearing Examination *Limited to one (1) routine exam per participant per benefit period*	You pay nothing; plan pays 100%	Not covered	**In-network**: Plan pays 100% of the maximum allowance, after the annual deductible **Out-of-network: Not covered**
Home Health Skilled Nursing Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Hospice Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Hospital Services (you pay) • **Inpatient** • **Outpatient** • **Special Services**	20% of the maximum allowance, after the annual deductible And $100 per day copayment for up to three (3) days per year per person for inpatient services	35% of the maximum allowance, after the annual deductible And $100 per day copayment for up to three (3) days per year per person for inpatient services	30% of the maximum allowance, after the annual deductible
Implantables (for the purpose of contraception) *Limited to once every five years*	Plan pays 100% of the maximum allowance, after the annual deductible and $100 copayment	You pay 35% of the maximum allowance, after the annual deductible	You pay 30% of the maximum allowance, after the annual deductible
Injections (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Rehabilitation or Habilitation Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Mammogram Services Preventive Screening (plan pays)	You pay nothing; plan pays 100% of the maximum allowance	Not Covered	**In-network:** You pay nothing; plan pays 100% of the maximum allowance **Out-of-network: Not covered**
Mammogram Services Diagnostic Service (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible

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Maternity – Physician Services (you pay)	$250 copayment, then plan pays 100% of the maximum allowance, not subject to the deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Maternity – Facility Services (you pay)	20% of the maximum allowance, after the annual deductible and $100 per day copayment up to three (3) days per year per person	35% of the maximum allowance, after the annual deductible and $100 per day copayment up to three (3) days per year per person	30% of the maximum allowance, after the annual deductible
Medical Services (you pay) • **Inpatient** • **Outpatient**	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Cardiac Rehabilitation Services (you pay) **(**up to a combined total of 36 visits per participant, per benefit period)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Pulmonary Rehabilitation Services (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Habilitation Therapy Services (you pay) • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Rehabilitation Therapy Services (you pay) • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Post-Mastectomy and/or Lumpectomy Reconstructive Surgery (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Prescription Drug Services	CVS Caremark manages prescription drug benefits; please refer to the *Summary Plan Description (SPD)* for more information.		
Selected Therapy (you pay)	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Skilled Nursing Facility (you pay) *Limited to 30 combined inpatient days per benefit period*	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Tobacco Cessation Counseling Services	Approved counseling services are covered at 100%		
Tobacco Cessation Medications	Most generic prescription medications are covered at 100%		

Temporomandibular Joint (TMJ) Syndrome Services (you pay) *Up to a combined $2,000 (in- and out-of-network) lifetime limit per participant*	50% of the maximum allowance, after the annual deductible	50% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Transplant Services (you pay) *Limited to a lifetime benefit limit of $5,000 for related living expenses*	20% of the maximum allowance, after the annual deductible	35% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible

Please refer to the Retiree Summary of Plan Description (SPD) for a detailed summary of all Retiree health benefits. The Retiree SPD is available on the benefits webpage.

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Pre-Medicare Prescription Drug Coverage At-a-Glance Chart

Plan A

You pay for the full cost of prescription drugs until you meet the per-individual deductible (or two individual deductibles per family).

Pre-Medicare Deductible:
- $125 individual
- $250 family

Once you meet the deductible, you will pay 25% coinsurance for your prescription drugs from the retail pharmacy. However, your coinsurance amount will be subject to a minimum and maximum copayment. If you order from the mail order pharmacy, you will pay a flat dollar copayment. This table shows your costs after you've met the deductible.

Plan B

In Pre-Medicare Plan B, you pay 100% of prescription drug costs until your eligible, combined medical and prescription drug expenses satisfy the deductible. Once you satisfy the deductible, you pay 30% of your prescription drug's cost until you reach the out-of-pocket maximum, then the plan pays 100% of covered services.

Prescription Drug Benefits At-a-Glance Chart

Feature	University of Idaho Plan A			University of Idaho Plan B	
	Retail Pharmacy		Mail Order	Retail Pharmacy	Mail Order
	30-day or less supply through CVS/Caremark pharmacies	90 day or less supply through CVS/Caremark pharmacies	90-day supply through CVS/Caremark	30-day or 90-day or less supply through CVS/Caremark pharmacies	90-day supply through CVS/Caremark
Generic	25% $12 minimum / $25 maximum	25% $36 minimum/ $75 maximum	$36	30% after deductible	30% after deductible
Formulary Brand Name*	25%* $25 minimum / $75 maximum	25%* $75 minimum / $225 maximum	$75	30% after deductible	30% after deductible
Non-formulary Brand* Name	25%* $40 minimum / $100 maximum	25%* $120 minimum / $300 maximum	$120	30% after deductible	30% after deductible

Please refer to the Retiree Summary of Plan Description (SPD) for a detailed summary of all Retiree health benefits. The Retiree SPD is available on the benefits webpage.

Coordinating Benefits With Other Coverages

If you or your eligible dependents are covered by more than one medical plan, reimbursements are coordinated between plans so benefits are not duplicated.

How the Plans Coordinate Coverage

Your medical benefits plan has maintenance of benefits (MOB) provision. This provision coordinates benefit payments from all medical plans that cover you and your eligible dependents, so that plan benefits are maintained at the level set by this plan after payments from all sources of coverage have been considered.

When you have a claim for expenses covered by two or more plans, one plan pays benefits first. This is known as the primary plan. The other plan(s), called the secondary plan(s), then determines how much of the covered services, if any, are to be paid from the secondary plan(s). The Order of Benefit Determination rules on the next page govern which plan will be considered primary and pay first, and which plan(s) will be considered secondary.

A "plan" is any of the following that provides benefits or services for medical or dental care or treatment:

- Group and non-group insurance contracts,
- Health maintenance organization (HMO) contracts and subscriber contracts,
- Closed panel plans or other forms of group or group-type coverage (whether insured or uninsured),
- Medical care components of long-term care contracts, such as skilled nursing care,
- Medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts.
- Medicare or any other governmental plan, as permitted by law,
- Separate parts of a plan for members of a group that are provided through alternative contracts that are intended to be part of a coordinated package of benefits are considered one plan and there is no MOB among the separate parts of the plan.

If separate plans are used to provide coordinated coverage for a group member, the separate plans are considered parts of the same plan, and there is no MOB among those separate plans.

A plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage,
- Accident-only coverage,
- Specified disease or specified accident coverage,
- Limited benefit health coverage, as defined by state law,
- School accident-type coverage,
- Benefits provided in long-term policies services,

- Medicare supplement policies, or
- Medicare, state plans under Medicaid or any other federal governmental plan, unless permitted by law.

When this medical benefits plan is primary, it pays or provides its benefits according to this plan's terms of coverage and without regard to the benefits of any other plan. ***When this medical benefits plan is secondary,*** it pays the amount necessary to ensure that the total combined amount you receive from this medical benefits plan and the primary plan is no greater than the amount you would have received under this medical benefits plan alone.

Example of Secondary Plan Payment
Under the Order of Benefit Determination Rules, if your enrolled spouse also has medical coverage through his or her employer, your spouse's employer's plan will be the primary payer. The University's benefit plan will be the secondary payer. This means the University's benefit plan will pay up to the amount allowed under this plan's coverage *less* the amount the primary plan already has paid.

For example, let's say that the University's benefit plan provides 80 percent coverage, your spouse's plan covers 50 percent, and your spouse has a covered, payable expense of $100. Your spouse's primary plan will pay 50 percent of the charge ($50), and the University's benefit plan will then pay 80 percent of the charge *less* $50 (in this case, $30) toward the remaining eligible expense.

But if your spouse's plan pays 80 percent and the University's benefit plan also allows 80 percent, no payment will be made by the University's benefit plan; this is because the maximum benefit of 80 percent has already been paid for the service.

Coordination of Benefits with Medicare
When you or your dependent reaches age 65 or becomes disabled, you or your dependent (as applicable) may be eligible for Medicare benefits. Medicare generally provides coverage for people age 65 or older, as well as for people entitled to Social Security disability benefits and those with end-stage renal disease. Once you become eligible for Medicare, Medicare will become your primary medical coverage and your University retiree medical coverage will become your secondary coverage (note that there is a limited exception in the case of end-stage renal disease).

Once you become eligible for Medicare, you should enroll in Medicare Parts A and B to remain eligible for the University of Idaho retiree health plan. That is because the Retiree Medical Plan integrates with Medicare on a maintenance of benefits basis as if you were enrolled in both Parts – even if you are not. If you do not enroll in Medicare Parts A and B, you may not receive the benefits you are entitled to and, therefore, may end up paying more for your medical care. In addition, you may be subject to late enrollment penalties if you don't enroll in Medicare when first eligible.

You should apply for Medicare two to three months before reaching age 65. Contact your local Social Security office before you reach age 65 for more information about Medicare and your eligibility.

Coordination of this Plan's Benefits with Other Benefits

The following Order of Benefit Determination Rules governs the order in which each plan will pay a claim for benefits.

- A plan that covers a patient as an active employee or a primary beneficiary is primary over a plan that covers the patient as a dependent.
- When both parents have medical coverage for their child(ren), the plan of the parent whose birthday comes earlier in the year is the primary plan. If the parents are divorced or legally separated, special rules apply:
- The plan of the natural parent with custody of a dependent child is primary. If the parent with custody remarries, the plan of the stepparent with custody pays second, the plan of the parent without custody pays third and the plan of the stepparent without custody pays last.
- However, if a court decree places financial responsibility for the dependent child's medical care on one parent, that parent's plan always pays first, regardless of who has custody of the child. The plan of the parent with custody pays second, the plan of the stepparent with custody pays third and the plan of the stepparent without custody pays last.
- A plan that covers the person as an active employee (that is, an employee who is neither laid off nor retired) or as a dependent of an active employee is the primary plan. A plan covering that same person as a retired or laid-off employee or as a dependent of a retired or laid-off employee is the secondary plan.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of such a person is the primary plan, and the plan covering that same person pursuant to COBRA or other continuation law is the secondary plan.
- If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is the primary plan, and the plan that covered the person for the shorter period of time is the secondary plan.

You may be asked, on an annual basis, to provide or confirm information about other plans under which you or your dependents are covered.