


## 2022 UNI Retiree Comprehensive Health Plan Options

January 1, 2022 through December 31, 2022

Plan Option	UNI PPO (Alliance Select)	UNI Blue Advantage (HMO)	UNI Dental Plan 2
<b>All premium amounts are calculated monthly.</b>			
<b>Single</b>	\$788.00	\$766.00	\$36.00
<b>Retiree &amp; Spouse, Not Medicare Eligible</b>	\$1,575.00	\$1,531.00	\$72.00
<b>Retiree &amp; Spouse, 1 Medicare Eligible, 1 Not Medicare Eligible</b>	\$1,417.00	\$1,378.00	\$72.00
<b>Family</b>	\$1,842.00	\$1,669.00	\$125.00
<b>Single Medicare Eligible</b>	\$630.00	\$613.00	\$36.00
<b>Retiree &amp; Spouse Medicare Eligible</b>	\$1,260.00	\$1,225.00	\$72.00
	UNI PPO (Alliance Select) <sup>1</sup>		UNI Blue Advantage (HMO)
	In-Network	Out-of-Network	Iowa and South Dakota Network
<b>Deductible</b> PPO Plan: deductible amounts aggregate and apply to each other	\$350 per person \$700 (maximum) per family Waived for certain covered services	\$1,000 per person \$2,000 (maximum) per family Applies to all covered services	\$100 per person \$200 (maximum) per family Waived for certain covered services
<b>Coinsurance Percentage</b>	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance
<b>Lifetime Benefit Maximum</b>	No Maximum	No Maximum	No Maximum
Wherever conflicts occur between the contents of this guide and the contracts, rules, regulations, or laws governing the administration of the various programs, the terms set forth in the various program contracts, rules, regulations, or laws shall prevail. Space does not permit listing all limitations and exclusions that apply to each plan. Before using your benefits, review the plan's coverage manual. Benefits provided can be changed at any time without the consent of participants.			

	UNI PPO (Alliance Select) <sup>1</sup>		UNI Blue Advantage (HMO)
	In-Network	Out-of-Network	Iowa and South Dakota Network
		Out-of-Network: Non-participating providers can balance bill***	No benefits from non-network providers unless a medical emergency <sup>4</sup> .
<b>Physician and Hospital Selection</b> <i>Find a Doctor or Hospital</i> <a href="https://www.wellmark.com/finder">https://www.wellmark.com/finder</a>	Member has choice of provider. <ul style="list-style-type: none"> <li>Iowa – Alliance Select PPO</li> <li>Nationwide – BlueCard PPO</li> </ul> <b>Unique Prefix: UON</b>	Member pays lower coinsurance if the provider participates in Wellmark's Alliance Select PPO network or the National BlueCard PPO network.  <b>Unique Prefix: UON</b>	Member designates a Primary Care Provider (PCP) from the Blue Advantage network. When you need medical care, your PCP will provide or coordinate your care with other Blue Advantage providers.  <b>Unique Prefix: XQW</b>
<b>Preventive Care (per ACA guidelines)</b> <ul style="list-style-type: none"> <li>Routine physicals</li> <li>Annual OB/GYN Exams</li> <li>Well Child Exams</li> <li>Immunizations</li> <li>Mammograms</li> </ul> <b>All of the above services must be scheduled once per calendar year.</b>	Covered at 100%	30% coinsurance after deductible	Covered at 100% Member may access OB/GYN provider for gynecological & maternity care
<b>Routine Eye Exams (One exam per 12 months)</b>	Covered at 100%	30% coinsurance after deductible	Covered at 100%
<b>Office Visit, Urgent Care &amp; Virtual Office Visit</b>	\$25 copay	30% coinsurance after deductible	\$15 copay
<b>Office Visit – Specialist<sup>5</sup></b>	\$40 office visit copay	30% coinsurance after deductible	\$15 office visit copay
<b>Chiropractic Care</b>	\$25 office visit copay	30% coinsurance after deductible	\$15 office visit copay Up to 12 visits per person per year without referral from PCP**
<b>Allergy</b>			
<ul style="list-style-type: none"> <li>Testing Non-Specialist</li> </ul>	\$25 office visit copay	30% coinsurance after deductible	\$15 office visit copay
<ul style="list-style-type: none"> <li>Testing Specialist</li> </ul>	\$40 office visit copay	30% coinsurance after deductible	\$15 office visit copay
<ul style="list-style-type: none"> <li>Shots &amp; Serum Non-Specialist</li> </ul>	\$25 office visit copay	30% coinsurance after deductible	\$15 office visit copay
<ul style="list-style-type: none"> <li>Shots &amp; Serum Specialist</li> </ul>	\$40 office visit copay	30% coinsurance after deductible	\$15 office visit copay

	UNI PPO (Alliance Select) <sup>1</sup>		UNI Blue Advantage (HMO)
	In-Network	Out-of-Network	Iowa and South Dakota Network
		Out-of-Network: Non-participating providers can balance bill***	No benefits from non-network providers unless a medical emergency <sup>4</sup> .
<b>Maternity Care</b>			
• Physician Office Visit	\$25 copay	30% coinsurance after deductible	\$15 copay
• Physician's Charges (global)	10% coinsurance after deductible	30% coinsurance after deductible	Paid in full
• Hospital Charges	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
<b>Inpatient Hospital &amp; Physician</b>	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
<b>Outpatient Hospital &amp; Physician</b>	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible
<b>Emergency Room</b> (Copay is waived if member is admitted as an inpatient of a facility immediately following ER Services.)	\$100 copay, then 10% coinsurance after deductible		\$100 copay
<b>Other Covered Services</b> <ul style="list-style-type: none"> <li>• Home Medical Equipment</li> <li>• Oxygen and Equipment</li> <li>• Prosthetics</li> <li>• Private Duty Nursing</li> <li>• Ambulance</li> </ul>	10% coinsurance after deductible	30% coinsurance after deductible	10% coinsurance after deductible

	UNI PPO (Alliance Select) <sup>1</sup>		UNI Blue Advantage (HMO)
	In-Network	Out-of-Network	Iowa and South Dakota Network
		<b>Out-of-Network: Non-participating providers can balance bill***</b>	No benefits from non-network providers unless a medical emergency <sup>4</sup> .
<b>Prescription Drugs (Retail)</b>	\$10 copay - Tier 1: Generic \$30 copay - Tier 2: Preferred \$50 copay - Tier 3: Non-Preferred \$50 copay - Tier 4 Limited \$75 copay – Specialty: Biosimilar \$115 copay - Specialty: Preferred \$215 copay - Specialty: Non-Preferred	Same as <i>In-Network</i> Rx copays plus “balance billed”***	\$10 copay - Tier 1: Generic \$30 copay - Tier 2: Preferred \$50 copay - Tier 3: Non-Preferred \$50 copay - Tier 4 Limited \$75 copay – Specialty: Biosimilar \$115 copay - Specialty: Preferred \$215 copay - Specialty: Non-Preferred
 <p>Wellmark Drug List for all Plans <a href="#">Blue Rx Complete Formulary Drug List</a> <a href="https://www.wellmark.com/my-employer-provides/prescription-drug-information">https://www.wellmark.com/my-employer-provides/prescription-drug-information</a></p>	<p>Copay applies to prescription drugs maximum out-of-pocket; unless you choose to receive a brand name when a generic equivalent is available. Wellmark will pay only what it would have paid for the equivalent generic drug. You will be responsible for your payment obligation for the equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug (this is also known as a “product penalty selection rule”).</p> <p>Mail Order: 2 copays for a 3 month supply (maintenance drugs only)</p>		
<b>Maximum Out-of-Pocket (MOP)</b>	<b>Medical</b> \$1,750 per person \$3,500 (maximum) per family	<b>Medical</b> \$4,000 per person \$8,000 (maximum) per family	<b>Medical</b> \$750 per person \$1,500 (maximum) per family
<b>Family Coverage:</b> <i>If one covered dependent reaches the single plan medical or prescription drug MOP, all covered services are paid at 100% for the remainder of the calendar year for that dependent. The remaining total family plan MOP would then be met through all covered dependents health and prescription drug expenses.</i>	<b>Prescriptions</b> \$2,600 per person \$5,200 (maximum) per family		<b>Prescriptions</b> \$2,600 per person \$5,200 (maximum) per family
	<ul style="list-style-type: none"> <li>All deductibles, coinsurance, and copays apply to MOP.</li> <li>Once MOP is met, all covered services are paid at 100% for the remainder of the calendar year.</li> </ul>	<ul style="list-style-type: none"> <li>All deductibles, coinsurance, and copays apply to MOP.</li> <li>Once MOP is met, all covered services are paid at 100% for the remainder of the calendar year; excludes <b>Balance Billed</b></li> </ul>	<ul style="list-style-type: none"> <li>All deductibles, coinsurance, and copays apply to MOP.</li> <li>Once MOP is met, all covered services are paid at 100% for the remainder of the calendar year.</li> </ul>

\* Premiums shown are 1/12 the annual cost and are effective January 1, 2020. Please visit <https://hrs.uni.edu/mybenefits/deductions> to learn about deductions.

\*\***Chiropractic Care** –UNI Blue Advantage (HMO) Plan has a limited number of in-network chiropractors. Ask your provider for a discount if they do not participate in the network.

\*\*\***Balance Billed:** Non-participating and Non-network providers can [balance bill](#) the member for the difference between their charge and the allowed amount. This balance bill is the member’s liability and does not apply to the deductible or out-of-pocket maximum.

<sup>1</sup>The UNI PPO (Alliance Select) is the base health plan for which UNI premiums are determined.

- For Single coverage, the full premium for the UNI PPO (Alliance Select) is applied to both of the plans.
- For Family coverage, 80% of the full premium for the UNI PPO (Alliance Select) is applied to both of the plans.

## Quick Guide to Selecting a UNI Comprehensive Retiree Health Plan

	UNI PPO (Alliance Select Network)	UNI Blue Advantage (HMO Network)
<b>In-Network</b>		
Significant number of medical providers in Iowa (including small portion of S. Dakota) <sup>1</sup>	✓	✓
Significant number of medical providers nationwide <sup>1</sup> , including Mayo Clinic, Rochester, MN	✓	
International coverage	✓	
National and international coverage when emergency**	✓	✓
Chiropractic care <sup>2</sup>	✓	✓
Coverage for routine eye exams	✓	✓
Does NOT require referral for in-network providers	✓	✓
<b>Out-of-Network</b>		
Nationwide coverage**	✓	
Coverage with guest membership <sup>3</sup>		✓
Does NOT require referral for out-of-network providers**	✓	
Prescription drugs: product selection penalty rule (please see pg. 4)	✓	✓
Requires a Primary Care Physician		✓
Coverage for medically necessary services**	✓	✓
Doctor On Demand - Video visits with board-certified physicians	✓	✓

- <sup>1</sup>Complete the Provider search to see if your providers are in-network: <https://www.wellmark.com/finder>
- <sup>2</sup>Limited providers in-network for UNI Blue Advantage (HMO); however many chiropractors offer co-pay discounts if they are considered outside the network. Talk to your current out-of-network chiropractor to learn if they would provide a discount.
- <sup>3</sup>Members traveling long-term, any covered dependents attending college out of state, or covered family members living apart are eligible to become a guest member any time they are outside the Wellmark Health Plan Network area for at least 90 days. Not all services covered under your medical benefits are covered under Guest Membership. To determine which services are covered under the Guest Membership program, call Wellmark. To receive covered services under the Guest Membership program, you must receive the service(s) from a Participating Provider.
- \*\*Balance Billed: Non-participating and Non-network providers can balance bill the member for the difference between their charge and the allowed amount. This balance bill is the member's liability and does not apply to the deductible or out-of-pocket maximum.

**<sup>4</sup>An emergency is as defined by the coverage manual:**

When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a Wellmark Health Plan Network Provider, covered services will be reimbursed as though they were received from a Wellmark Health Plan Network Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

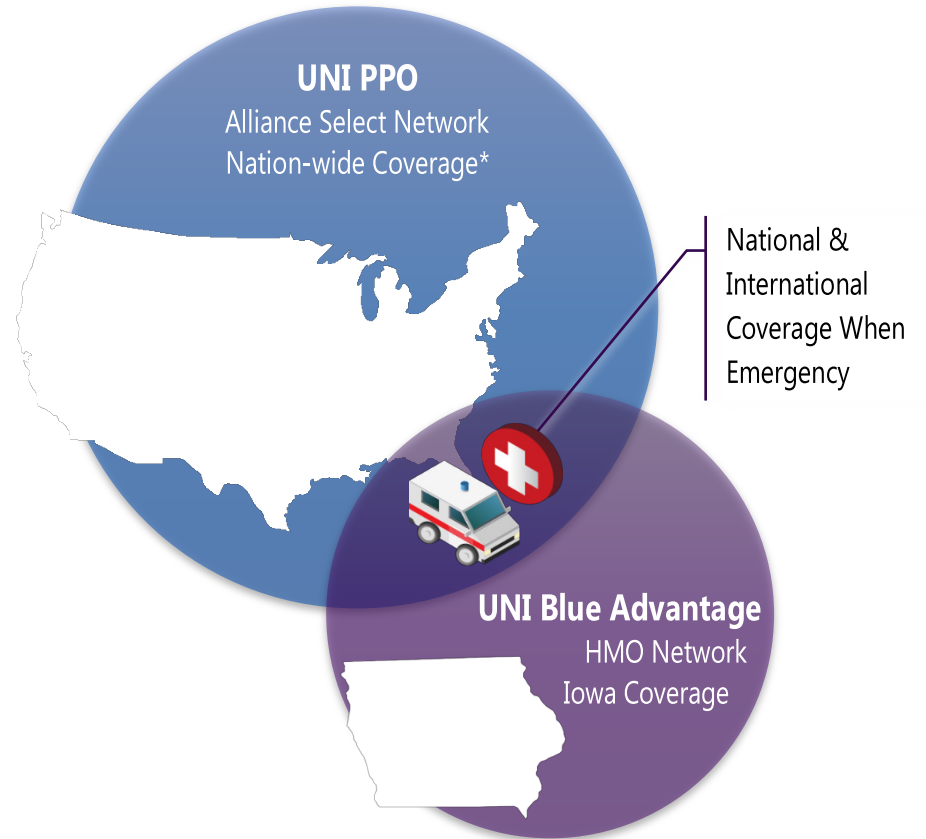
**<sup>5</sup>The following are considered Primary Care Physicians (PCP):**

- Family practitioners
- General practitioners
- Internal medicine practitioners
- Obstetricians/gynecologists
- Pediatricians
- Physician assistants
- Advanced registered nurse practitioners

Other providers (not designated personal doctors) include: chiropractors, speech pathologists, occupational therapists and physical therapists. Mental Health would also be considered as non-specialist treatment in order to pass mental health parity testing.

**All other providers are considered specialists.**

Examples of these include cardiologists, dermatologists, and orthopedists.



**\*Blue Cross Blue Shield Global Core**

As a Blue Cross and Blue Shield Plan member, your health care benefits are with you at home and abroad. Within the United States, you're covered whether you need care in urban or rural areas. Outside the United States, you have access to doctors and hospitals in nearly 200 countries and territories around the world through the Blue Cross Blue Shield Global Core program.

<https://bcbsglobalcore.com>

## Glossary of Benefit Terms

UNI PPO (Alliance Select)		UNI Blue Advantage (HMO)	
Coinsurance	Your share of the costs of a covered health care service after the deductible is met. This is calculated as a percent of the allowed amount for the service and will be owed until the max out-of-pocket is met.	Coinsurance	Your share of the costs of a covered health care service after the deductible is met. This is calculated as a percent of the allowed amount for the service and will be owed until the max out-of-pocket is met.
Copayment	A fixed amount you pay for a covered health care service, usually when you receive the service.	Copayment	A fixed amount you pay for a covered health care service, usually when you receive the service.
Deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.	Deductible	The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
In-Network	Providers who contract with your health plan. Your payments may be less when seeking treatment from an in-network facility or physician.	In-Network	Providers who contract with your health plan. Your payments may be less when seeking treatment from an in-network facility or physician.
Tier 4 Limited-value drugs	Limited-value drugs are combination products, lifestyle drugs, or drugs with more cost-effective options available on lower tiers (i.e. generics)	Tier 4 Limited-value drugs	Limited-value drugs are combination products, lifestyle drugs, or drugs with more cost-effective options available on lower tiers (i.e. generics)
Max out-of-pocket (MOP)	This is the most you could pay during a coverage period (usually one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Premiums, <a href="#">pre-service review penalties</a> , <a href="#">balance-billed charges</a> , and health care this plan doesn't cover do not apply to MOP. For this plan, the MOP is \$1,750 per person, and a maximum \$3,500 per family for health care expenses. The MOP is \$2,600 per person and a maximum \$5,200 per family for the prescription. The in-network health and prescription out of pocket amounts accumulate separately.	Max out-of-pocket (MOP)	This is the most you could pay during a coverage period (usually one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Premiums, <a href="#">pre-service review penalties</a> , <a href="#">balance-billed charges</a> , and health care this plan doesn't cover do not apply to MOP. For this plan, the MOP is \$750 per person, and a maximum \$1,500 per family for health care expenses. The MOP is \$2,600 per person and a maximum \$5,200 per family for the prescription. The in-network health and prescription maximum out of pocket amounts accumulate separately.