University of Idaho

2013 Medical and Prescription Drug Coverage At-a-Glance Chart

	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In- and out-of-Network
Annual Deductible*			
Individual	$400	$600 per individual	$1,500
Family	$1,200		$3,000
Out-of-Pocket Maximum* (Once you satisfy the deductible, you pay coinsurance where applicable until out-of-pocket maximum is satisfied, then the plan pays 100% of covered services.)			
Individual	$3,600	$5,200 per individual	$3,100
Family	$10,800		$6,200**
Total Annual Cost Exposure (deductible plus out-of-pocket maximum)			
Individual	$4,000 PLUS all copayments, prescription drug deductible and copayments	$5,800 per individual PLUS all copayments, prescription drug deductible and copayments	$4,600
Family	$12,000 PLUS all copayments, prescription drug deductible and copayments		$9,200
Preventive Care			
Preventive care/wellness services	You pay nothing; plan pays 100%	Not covered	You pay nothing; plan pays 100% of the maximum allowance
Office Visits (you pay)			
Primary care office visits	$25 copayment per visit, not subject to deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Specialist care office visits			
Non-physician services, such as labwork, imaging, etc.	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	
Behavioral Health Benefits (you pay)			
Inpatient Services	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Outpatient psychotherapy services	$25 copayment per visit; not subject to deductible	35% of the maximum allowance, after the deductible	
Hospital Benefits (you pay)			
Emergency services	20% of the maximum allowance, after the deductible	20% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Inpatient	20% of the maximum allowance, after the deductible and $100 per day copayment, up to $300 per year per person	35% of the maximum allowance, after the deductible and $100 per day copayment, up to $300 per year per person	
Outpatient	20% of the maximum allowance, after the deductible	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible

Every effort has been made to make certain that the information in this communication is accurate. However, this communication is only intended to give you an overview of your benefit plans and does not contain all the details about the benefits provided, exclusions and other terms and conditions of the plans. Your benefits are determined according to official plan documents. If the information in this communication differs from the plan documents, the plan documents will govern in all cases. The University may amend or terminate these plans or any benefits provided by these plans at any time. Neither this communication nor any of the University's policies for benefit plans should be considered a contract for purposes of employment or payment of compensation or benefits.

Medical Coverage (Continued)

	Standard PPO		High Deductible Health Plan (HDHP)
	In-Network	Out-of-Network	In- and out-of-Network
Maternity Services (you pay)			
Physician services	$250 co-payment, then plan pays 100%; not subject to deductible or coinsurance	35% of the maximum allowance, after the deductible	30% of the maximum allowance, after the deductible
Hospital services	20% of the maximum allowance, after the deductible and $100 per day copayment for inpatient services, up to $300 per year per person	35% of the maximum allowance, after the deductible and $100 per day copayment for inpatient services, up to $300 per year per person	

** In the Standard PPO, copayments do not count toward satisfying the annual deductible or out-of-pocket maximum.*

*** When your family has satisfied the $3,000 deductible, you pay coinsurance for covered services for all family members. If one family member's covered services satisfy the $3,100 individual embedded out-of-pocket maximum, the plan will pay 100% for all covered services for that family member. When any combination of family members' covered services satisfies the overall $6,200 family out-of-pocket maximum, also satisfying the total annual cost exposure of $9,200, the plan pays 100% of covered services for all family members for the remainder of the calendar year.*

2013 Prescription Drug Coverage

	Standard PPO			High Deductible Health Plan (HDHP)
Prescription Drug Deductible				
Individual	$125			Not applicable
Family	$250			
Drug Type	Retail Pharmacy (30-day or less supply through CVS Caremark pharmacies)	Mail-Order Pharmacy (90-day supply through CVS Caremark)		
		Retail (90-day supply)	Mail Order (90-day supply)	
Generic	25% ($12 min; $25 max)	25% ($36 min; $75 max)	$36	Pay 100% of the drug's cost until you satisfy the deductible, then pay 30% of the maximum allowance
Formulary Brand Name*	25% ($25 min; $75 max)	25% ($75 min; $225 max)	$75	
Non-Formulary Brand Name*	25% ($40 min; $100 max)	25% ($120 min; $300 max)	$120	

** If a brand name drug is purchased when an equivalent generic is available, you pay the appropriate brand copayment, plus 100% of the cost difference between the generic and brand.*

Save Money with the Mail Order Pharmacy

If you take medications for a chronic condition, you may save money by having 90-day prescriptions filled. Receive a 90-day supply at a participating retail pharmacy or through the mail order pharmacy. You will pay three retail copayments for 90-day prescriptions filled at the retail pharmacy, but a lower 90-day copayment at the mail order pharmacy. Find a participating pharmacy by calling the number listed on your CVS Caremark ID card

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