Choosing a Retiree Health Plan

University of Idaho Benefits

You must be enrolled in an active University of Idaho employee medical plan to transition to the retiree medical plan. Please review the information provided and consider your options carefully. ***University of Idaho retiree health plan elections are irrevocable.***

Administration

The active and retiree health plans run on a calendar year basis, January through December. There is no annual enrollment period for retirees.

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. Please refer to the Retiree Summary Plan Description (SPD) available on the Benefit Services website at www.uidaho.edu/human-resources/benefits.

Retiree Medical Plan Options

You have two medical plan choices,

- Retiree PPO Plan
- Retiree High Deductible Health (HDHP)

Your retiree health plan election (Retiree PPO or Retiree HDHP) applies to all dependents you enroll on your coverage. **There will be no future opportunity to switch choices between the plans.** The attached Pre-Medicare and Post-Medicare At-a-Glance documents outline the benefits of both University of Idaho Retiree Health Plans.

If you retire mid-year, deductibles may or may not be carried forward, depending on the retiree health plan you elect as outlined below:

Current ***Active*** Health Plan Coverage	Retiree Health Plan Elected	Deductible Carries Forward?
Standard PPO	Retiree PPO Plan	YES
Standard PPO	Retiree HDHP	NO
High Deductible Health Plan (HDHP)	Retiree PPO Plan	NO
High Deductible Health Plan (HDHP)	Retiree HDHP	YES

Prescription Drug Coverage

Pre-Medicare (All Tiers)

- Both university retiree medical plans PPO and HDHP provide prescription drug coverage until you become Medicare eligible and/or turn 65.

Post-Medicare

- **Tier I Retiree PPO Plan** – Prescription drug coverage is provided through SilverScript, a Medicare Part D group plan. Additional information on the SilverScript plan is attached.
- **Tier I Retiree HDHP** – Prescription drug coverage **ends with Medicare eligibility and is therefore not covered once you turn 65.** You must purchase a separate Medicare Part D drug plan to have continued prescription drug coverage. A certificate of creditable coverage will be mailed to your home upon Medicare eligibility. This certificate allows you to transition to Medicare Part D coverage effective the first of the following month after your University of Idaho Retiree prescription drug plan terminates.
- **Tiers II, III & IV, Retiree PPO Plan and Retiree HDHP** – Prescription drug coverage **ends with Medicare eligibility and is therefore not covered once you turn 65.** You must purchase a separate Medicare Part D drug plan to have continued prescription drug coverage.

Medicare Enrollment is Required

In order to participate in the University of Idaho Retiree Health Plan you MUST enroll in Medicare Parts A and B when you first become eligible. Unless you have a Medicare qualifying disability that qualifies you for Medicare coverage sooner, Medicare should be effective the first of the month in which you turn 65.

If you fail to enroll in Medicare Parts A and B when you are first eligible, your participation in the University of Idaho Retiree Health Plan will terminate and you will forfeit all rights to rejoin the Plan at a later date.

The University of Idaho Retiree Health Plan is not a Medicare Supplement. Once you are enrolled in Medicare Parts A and B, Medicare becomes the primary insurer, and the university retiree health plan is secondary. The university retiree health plan coordinates benefits with other coverages and processes claims according to **maintenance of benefits (MOB) provision**. This provision reduces covered charges by the amount the primary plan has paid, and then secondarily processes claims according to the university retiree health plan, not to exceed what the university retiree health plan would have allowed if primary. This ensures benefits are maintained at the level set by the university retiree health plan after payments from all sources of coverage have been considered.

Spouse and Other Dependent Eligibility

This is your **ONLY** opportunity to add your spouse or other eligible dependents currently enrolled, to your University of Idaho Retiree Health Plan. There will be no future opportunity to add existing eligible dependents except under the following circumstances.

- If your spouse is an active University of Idaho employee, he/she may be added to your

plan on the day following their date of retirement or termination.
- Retirees may also add new spouses and dependents within 30 days from the date of marriage or 60 days from date of birth or adoption.
- Loss of other health plan coverage is **NOT** a qualifying event to enroll dependents on your retiree health plan.

Retiree Death Benefit

Tier I retirees who transition to and maintain enrollment in the Tier I post-Medicare University of Idaho Retiree Health Plan automatically qualify for a death benefit. The maximum death benefit is $10,000, or less, depending on the coverage level in place at the time of retirement. The Plan, administered by the University of Idaho, pays the death benefit to your spouse or other designated beneficiary upon your death. A beneficiary form will be provided to you, along with other retirement forms, closer to your retirement date.

Paying for your Retiree Health Coverage

Sick Leave Conversion: Available to **Tier IV retirees only**. One half of your unused sick leave hours available at the time of retirement, accrued since July 1, 1976, not to exceed a maximum of 600 hours, may be used to pay for the cost of **Tier IV** retiree health plan coverage for the retiree. This applies to the Retiree PPO Plan and Retiree HDHP. Sick leave conversion may not be used to pay for the cost of coverage for dependents, dental or vision coverage, voluntary benefits, or ported life insurance.

Please disregard invoices you may receive for your Tier IV retiree coverage. Your sick leave credits will be applied in lieu of payment.

For all other Tiers (I, II and III), unused sick leave is not paid out and has no cash value. There are no other conversion options available to you.

Health Reimbursement Account (HRA): Once you are Medicare eligible under **Tier II or Tier III, Retiree PPO Plan**, the university provides a reimbursement stipend in lieu of prescription drug coverage. The reimbursement is provided through an HRA and is administered by HealthEquity. The HRA stipend is not available under any other retirement tiers or plans. A separate Frequently Asked Questions (FAQ) describing the HRA stipend is attached.

Monthly Billings: You will receive monthly billings for the plan choices you make and the dependents that you enroll. Pre-authorized bank draft (ACH) is **required** to pay for your cost of retiree health coverage. A Pre-Authorized Checking Registration Form for Retirees is available on the Benefit Services website. Checks, credit cards and bill-pay are not accepted.

Please note: The first invoice you receive will include charges for the first and second months of enrollment.

If you do not pay your cost of retiree and dependent costs for the Retiree PPO Plan or Retiree HDHP coverage in a timely manner, all University sponsored retiree health coverage will end, and you will forfeit your rights to join the Plan at any later date.

Other Coverage Information

COBRA Coverage: You will have the opportunity to elect COBRA continuation coverage for medical, dental and vision upon leaving active employment with the university. This is a legal notice required by law through the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as retirement and voluntary or involuntary job loss.
Our third-party benefit administrator will mail a COBRA packet to your home address approximately 2 – 3 weeks following your retirement date. **Disregard the COBRA notification for medical coverage for YOU if you are enrolling in a University of Idaho Retiree Health plan.** If you are not adding your covered dependent(s) to your University of Idaho Retiree Health plan, you may elect COBRA medical coverage for them. COBRA dental and/or vision coverage may also be elected for you and your covered dependents. You and your covered dependents can remain on COBRA coverage for a maximum of 18 months from the date of your retirement.

Dental and Vision Coverage: Dental and vision coverage are not included in your retiree health plan. Individual dental and/or vision coverage may be available through individual plans with Delta Dental, VSP, your spouse or the Health Insurance Marketplace. COBRA dental and vision coverage may be elected for you and your covered dependents for a maximum of 18 months from the date of your retirement.

Life Insurance Adjustment and Portability Options: Dependent life insurance ends upon retirement. Portability for active employee life insurance, if less than age 75, is available for 30 days from the last day worked.

Effective Date, Resignation and Forms

Effective Date: If you transition to the University of Idaho Retiree Health plan, the effective date of your retirement must be the **last working day of the month**. You are required to work on your last day as an active employee.

If you will not transition to the University of Idaho Retiree Health plan, your active medical plan and all other benefits will terminate on your last day worked. You are required to work on your last day as an active employee.

Resignation Notice: A copy of your resignation notice, and the department/unit acknowledgment must be provided to Benefit Services.

Forms: Approximately 2 months before your retirement date, Benefit Services will email documents for you to complete and return in order to finalize your retirement.

University of Idaho Retiree Health Plan Tiered Eligibility

Tier Criteria	Tier I	Tier II		Tier III		Tier IV	
	Pre & Post Medicare	**Pre-Medicare**	**Post-Medicare**	**Pre-Medicare**	**Post-Medicare**	**Pre-Medicare**	**Post-Medicare**
Must Be Hired Before	January 1, 2002 **AND**	January 1, 2002 **AND**	January 1, 2002 **AND**	January 1, 2002 **AND**	January 1, 2002 **AND**	July 1, 2020 **AND**	July 1, 2020 **AND**
Minimum Years of Qualified Service	30 Years **OR**	30 Years **OR**	30 Years **OR**	30 Years **OR**	30 Years **OR**	10 Years **AND**	10 Years **AND**
Minimum Age & Service Rule	**Rule of 80** Sum of Age (minimum 55 years) And Qualified Service (minimum 5 years) **OR** Minimum Age 64 Years AND Minimum 15 Years Qualified Service	**Rule of 80** Sum of Age (minimum 55 years) And Qualified Service (minimum 15 years)	**Rule of 80** Sum of Age (minimum 55 years) And Qualified Service (minimum 15 years)	**Rule of 90** Sum of Age (minimum 55 years) And Qualified Service (minimum 20 years)	**Rule of 90** Sum of Age (minimum 55 years) And Qualified Service (minimum 20 years)	At least age 55	At least age 55
Date Criteria Must Be Met	September 30, 2007 (may retire later)	June 30, 2011 (may retire later)	June 30, 2011 (may retire later)	**After** June 30, 2011 (may retire later)	**After June 30, 2011, AND ON or BEFORE December 31, 2020** (may retire later)	No Required Date	**ON or BEFORE December 31, 2020** (may retire later)

University of Idaho Retiree Health Plan - Benefits Overview

Benefit	Tier I				Tier II				Tier III				Tier IV			
	Pre-Medicare		Post-Medicare		Pre-Medicare		Post-Medicare		Pre-Medicare		Post-Medicare		Pre-Medicare		Post-Medicare	
	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP
Medicare A & B Enrollment Required			Yes	Yes			Yes	Yes			Yes	Yes			Yes	Yes
Medicare is Primary			Yes	Yes			Yes	Yes			Yes	Yes			Yes	Yes
Retiree PPO Plan Option	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Retiree High Ded Health Plan (HDHP) Option	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prescription Drug Plan - CVS Caremark	Yes	Yes			Yes	Yes			Yes	Yes			Yes	Yes		
HDHP Preventive Prescription Drugs																
Prescription Drug Plan - SilverScripts			Yes													
Health Reimbursement Account Stipend (HRA)							Yes				Yes					
Sick Leave Conversion													Yes	Yes	Yes	Yes
Dental Coverage																
Vision Coverage																
Death Benefit - Retiree Only			Yes	Yes												
Portability of Life Insurance - Retiree Only	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
NCPERS - PERSI members ONLY	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Employee Assistance Program (EAP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Creditable Coverage	Yes	Yes	Yes		Yes	Yes			Yes	Yes			Yes	Yes		

University of Idaho Retiree Health Plan
2024 Pre-Medicare Monthly Rates

Pre-Medicare (No Medicare)	Tier I		Tier II		Tier III		Tier IV	
	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP
Retiree Only	$77.09	$0.00	$106.88	$0.00	$106.88	$0.00	$873.50*	$701.38*
Retiree + Spouse	$950.59	$701.37	$980.38	$701.37	$980.38	$701.37	$1,747.00	$1,402.75
Retiree + Child	$286.36	$168.03	$316.15	$168.03	$316.15	$168.03	$1,082.77	$869.41
Retiree + Children	$668.51	$474.88	$698.30	$474.88	$698.30	$474.88	1,464.92	$1,1176.26
Retiree + Family	$1,542.02	$1,176.26	$1571.81	$1,176.26	$1,571.81	$1,176.26	$2,338.43	$1,877.64

* Tier IV (Retiree Only) Eligible for Sick Leave Conversion

2024 Pre-Medicare Benefits At-a-Glance

Benefits	Pre-Medicare University of Idaho Medical Plans		
	Retiree PPO Plan	**Retiree PPO Plan**	**Retiree HDHP**
	In-Network	**Out of Network**	**In- and Out-of-Network**
Annual Deductible for Medical Services and Supplies (you pay)			
Individual or Self-Only	$800	$1,200 per individual	$1,900
Family	$2,400		$3,800
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		

2024 Pre-Medicare Benefits At-a-Glance

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

2024 Pre-Medicare Benefits At-a-Glance

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

2024 Pre-Medicare Benefits At-a-Glance

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%		

2024 Pre-Medicare Benefits At-a-Glance

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.

2024 Pre-Medicare Benefits At-a-Glance

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

Retiree PPO Plan

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.

Retiree HDHP

In Pre-Medicare Retiree HDHP, 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

	University of Idaho Retiree PPO			University of Idaho Retiree HDHP	
	Retail Pharmacy		Mail Order	Retail Pharmacy	Mail Order
Feature	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 aged 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.

2024 Pre-Medicare Benefits At-a-Glance

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 in 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.

University of Idaho Retiree Health Plan
2024 Monthly Rates
Retiree Post-Medicare / Spouse Pre-Medicare

Retiree Post-Medicare Spouse Pre-Medicare	Tier I		Tier II		Tier III		Tier IV	
	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP	Retiree PPO	Retiree HDHP
Retiree Only	$45.25	$0.00	$49.62	$0.00	$49.62	$0.00	$216.41*	$205.68*
Retiree + Spouse	$918.75	$701.38	$923.12	$701.38	$923.12	$701.38	$1,089.91	$907.06
Retiree + Child	$305.25	$207.48	$292.38	$207.48	$292.38	$207.48	$459.16	$413.16
Retiree + Children	$780.06	$586.41	$735.70	$586.41	$735.70	$586.41	$902.49	$792.09
Retiree + Family	$1,653.56	$1,287.79	$1,609.20	$1,287.79	$1,609.20	$1,287.79	$1,775.99	$1,493.47

* Tier IV (Retiree Only) Eligible for Sick Leave Conversion

2024 Post-Medicare Medical Plan At-a-Glance

Benefits	Post Medicare University of Idaho Medical Plans	
	Retiree PPO Plan	**Retiree HDHP**
Annual Deductible for Medical Services and Supplies (you pay)		
Annual Deductible (you pay)	$700 per individual	$1,900 per individual
Preventive Care & Wellness Services – for specifically listed services (plan pays)	You pay nothing for eligible, in-network care; plan pays 100% of the maximum allowable	You pay nothing for eligible, in-network care; plan pays 100% of the maximum allowable

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 for 100% of covered services.		
Cost-Share Maximum	$2,850 per individual	$3,100
Lifetime Benefit Maximum	Unlimited	
Ambulance Transportation Services (Ground or Air) (you pay)	20% 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	30% of the maximum allowance, after the annual deductible

2024 Post-Medicare Medical Plan At-a-Glance

Behavioral Health - Outpatient Psychotherapy Services (you pay)	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Behavioral Health - Facility & Other Professional Services (you pay)	20% 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	30% of the maximum allowance, after the annual deductible
Colonoscopy & Sigmoidoscopy Preventive Screen (you pay)	You pay nothing; plan pays 100% of the maximum allowance	You pay nothing; plan pays 100% of the maximum allowance
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	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)
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)	30% of the maximum allowance after the separate Bariatric deductible (Covered at a Blue Cross of Idaho Center of Excellence Provider Only)
Contraceptive Services Birth Control Pills	See Prescription Drug Benefits for more information	Not covered
Contraceptive Services Diaphragms & IUD Depo Provera Injections (you pay)	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Dental Services related to Accidental Injury (you pay)	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Diabetes Self-Management Education (you pay) *Limited to $500 per benefit period*	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Diagnostic Services (you pay) *Excluding eligible wellness & preventive care services)*	20% 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	30% of the maximum allowance, after the annual deductible
Emergency Room Copay (you pay)	$100 copay per visit	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	30% of the maximum allowance, after the annual deductible
Hearing Examination *Limited to one (1) routine exam per participant per benefit period*	Plan pays 100% of the maximum allowance, after the annual deductible	Plan pays 100% of the maximum allowance, after the annual deductible
Hearing Aid Appliances and Fitting Exams (you pay) *Limited to $800 per participant per lifetime*	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible

2024 Post-Medicare Medical Plan At-a-Glance

Home Health Skilled Nursing Services (you pay)	20% 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 *(only from a contracted Hospice)*	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	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 30% of the maximum allowance, after the annual deductible
Injections (you pay)	20% 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	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 for in-network services	You pay nothing; plan pays 100% of the maximum allowance for in-network services
Mammogram Services Diagnostic Service (you pay)	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Maternity – Physician Services (you pay)	$250 copayment, then plan pays 100% of the maximum allowance, not subject to the 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	30% of the maximum allowance, after the annual deductible
Medical Services (you pay) • **Inpatient** • **Outpatient**	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Cardiac Rehabilitation Services (up to a combined total of 36 visits per participant, per benefit period)	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Pulmonary Rehabilitation Services	20% of the maximum allowance, after the annual deductible	30% of the maximum allowance, after the annual deductible
Outpatient Habilitation Therapy Services • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	Plan pays 100% of the maximum allowance, after $35 copayment, not subject to the deductible	You pay 30% of the maximum allowance, after the annual deductible

2024 Post-Medicare Medical Plan At-a-Glance

Outpatient Rehabilitation Therapy Services • Occupational Therapy • Physical Therapy • Respiratory Therapy • Speech Therapy	20% 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	30% of the maximum allowance, after the annual deductible
Prescription Drug Services (Tier 1 participants only)	SilverScript manages prescription drug benefits; please see the *Prescription Drug Benefits section* of the Summary Plan Description (SPD) for more information	Not covered
Selected Therapy (you pay)	20% 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 inpatient days per benefit period*	20% of the maximum allowance, after the annual deductible, and $100 per day co-payment up to 3 days per benefit period	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 lifetime limit per participant*	50% of the maximum allowance, after the annual deductible	50% of the maximum allowance, after the annual deductible
Transplant Services (you pay)	20% 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.

2024 Post-Medicare Medical Plan At-a-Glance

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.

However, 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 aged 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.

2024 Post-Medicare Medical Plan At-a-Glance

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 in 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.

Your Transition to Retirement

University of Idaho Benefits

The transition from active employee to the University of Idaho Retiree Health Plan can take approximately four weeks after your last **pay** date as an active employee. Much of this is due to processing and the two-week lag in payroll. ***Please be assured, you DO have coverage under the retiree health plan during this time and there will be no break in your coverage.*** If a medical emergency occurs, you are covered under the retiree health plan you elected. In the event of an emergency, you may contact Benefit Services for assistance with your health plan eligibility.

Below are a few notes to assist you in a smooth transition from active health plan coverage to retiree coverage:

1. Please avoid scheduling any routine health exams or procedures during the transition period (first 2 – 4 weeks). Refill any prescriptions and attend medical visits you may need in advance of your retirement effective date. If you are unable to do so, it may be necessary for you to pay the cost out of pocket and submit a manual claim to the prescription drug administrator and/or Blue Cross of Idaho once the transition is complete.

2. Utilize your active employee benefits for vision and dental **BEFORE** you retire.

   a) There are no routine vision exam or hardware benefits under the university retiree health plans. Cataracts and medically based vision exams are benefits under the medical plans.

   b) There are no dental benefits under the university retiree health plans.

   c) COBRA dental and vision coverage may be elected for you and your covered dependents for a maximum of 18 months (see more below)

3. You will have the opportunity to elect COBRA continuation coverage for medical, dental and vision upon leaving active employment with the university. This is a legal notice required by law through the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as retirement and voluntary or involuntary job loss.

   Our third-party benefit administrator will mail a COBRA packet to your home address approximately 2 – 3 weeks following your retirement date. **Disregard the COBRA notification for medical coverage for YOU if you are enrolling in a University of Idaho Retiree Health plan.** If you are not adding your covered dependent(s) to your University of Idaho Retiree Health plan, you may elect COBRA medical coverage for them. COBRA dental and/or vision coverage may also be elected for you and your covered dependents. You and your covered dependents can remain on COBRA coverage for a maximum of 18 months from the date of your retirement.

4. Your Blue Cross of Idaho subscriber ID will remain the same. You may/may not receive new cards, depending on the retiree health plan you elect as outlined below:

Current Active Employee Coverage	Retiree Health Plan Elected	Receive New Cards?
Standard PPO	Retiree PPO	NO
Standard PPO	Retiree HDHP	YES
High Deductible Health Plan (HDHP)	Retiree PPO	YES
High Deductible Health Plan (HDHP)	Retiree HDHP	NO

5. If you participated in the ***Health Care Flexible Spending Account (FSA)*** as an active employee, you have 90 days after your last day in pay in status to submit claims ***incurred during the current year of active employment***. Expenses incurred after you retire are not eligible for reimbursement. The maximum claim reimbursement is your annual election amount.

6. Once you enroll in Medicare Parts A or B, you are no longer eligible to contribute to a **Health Savings Account (HSA)**. The money you have accrued in your HSA is yours. After retirement, the university no longer pays the administrative fees associated with the HSA account. The monthly administrative fee is currently $3.95, if your balance is below $2,500. The vendor fee is subject to change. You may call HealthEquity at 1-866-346-5800 with any questions. http://www.healthequity.com/

7. If you are Medicare eligible at the time of your retirement, please provide a copy of your Medicare ID card to Benefit Services and Blue Cross of Idaho as proof of enrollment in Medicare Parts A and B. Remind them that Medicare is now primary.

8. If you and/or your spouse are eligible for Medicare upon retirement, Benefit Services will provide a certificate of creditable coverage for Part D of Medicare and the employer notice to Medicare (CMS-L56E) confirming continuous coverage required for Parts A and B.

9. If you have accrued annual leave, please review your leave balance with your supervisor or department head. You may be asked to use some or all of the annual leave prior to retirement. Unused annual leave is paid out on your final paycheck. You may also choose to donate your accrued annual leave to the Shared Leave Program.

10. If you are eligible for sick leave conversion (Tier IV only) please disregard any invoices you receive after transitioning to the retiree health plan.

11. Contact the University of Idaho Retiree Association (UIRA) to become a member. Membership is free and open to all University retirees. For additional information and to join go to www.uidaho.edu/faculty-staff/uira/join.

12. Consider reviewing and organizing your personal/professional papers of historic importance for donation to University Archives. The institutional memory of the University depends on having written records that reflect the accomplishments of both departments and individuals. For more information, please contact University Archives at (208) 885-7951 or email at libspec@uidaho.edu.

University of Idaho Retiree Resource Directory

Resource	Plan Administrator	Phone	Website
Medical Plan	Blue Cross of Idaho	866-685-2258	bcidaho.com
Prescription Drug Plan (Pre-Medicare)	CVS Caremark	888-202-1654	caremark.com
Prescription Drug Plan (Tier I, Retiree PPO Plan)	CVS Caremark – SilverScripts	855-539-4715	caremark.com
Health Savings Account (HSA) Flexible Spending Accounts (FSA)	Health Equity	888-769-8696	healthequity.com
Employee Assistance Program (EAP)	KEPRO	800-999-1077 Available 24/7	EAPhelplink.com Code UI1
Death Benefit (Tier 1 Retirees Only)	University of Idaho	208-885-3697	uidaho.edu/benefits
Group Life Insurance Portability	The Standard	800-378-4668 Ext 6785	standard.com
NCPERS – PERSI Life Insurance	NCPERS	800-525-8056	www.ncpers.memberbenefits.com
Public Employees Retirement System of Idaho (PERSI)	PERSI	800-451-8228	persi.idaho.gov
Optional Retirement Program (ORP)	TIAA	800-842-2733	tiaa.org
	Corebridge	800-448-2542	valic.com
90 Days From Retirement (Medicare Counseling)	Jennifer Johnson	208-973-9704	jen@medicaregi.com
	Michael McShane	208-973-9702	michael@medicaregi.com
Medicare	Medicare	800-633-4227	www.medicare.gov
Social Security Administration	Social Security	877-405-9796	www.ssa.gov
Senior Health Insurance Benefits Advisors (SHIBA) Idaho	SHIBA	800-247-4422	www.doi.idaho.gov/shiba
Senior Health Insurance Benefits Advisors (SHIBA) Washington	SHIBA	800-562-6900	www.insurance.wa.gov/statewide-health-insurance-benefites-advisors-shiba
University of Idaho Retiree Association (UIRA)	University of Idaho		www.uidaho.edu/governance/faculty-staff/uira
University of Idaho Benefit Services	University of Idaho	208-885-3697	uidaho.edu/benefits

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