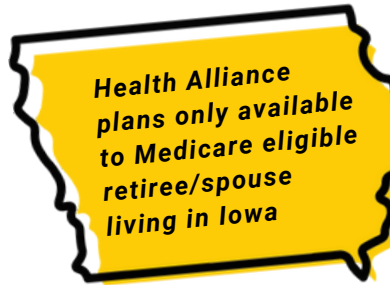


IOWA

SUMMARY OF RETIREE HEALTH PLANS

EFFECTIVE JAN. 1, 2024 - DEC. 31, 2024



HEALTH ALLIANCE

HMO Plus Rx

HEALTH ALLIANCE

PPO Plus Rx

WELLMARK BC/BS

UIChoice

WELLMARK BC/BS

UISelect

If you are Medicare eligible, all plans require your enrollment in Medicare Parts A & B, but not Part D.

*Please note: the **blue highlighted** items are plan provisions that will change in 2024.

PROVIDERS	In-network only, except in an emergency	In-network or Out-of-network Can visit any doctor who accepts Medicare, but member will pay less with in-network providers	Level 1: All UI Health Care Providers + affiliated providers. Level 2: Blue Choice network providers not in Level 1 Level 3: Any provider outside of Level 1 & 2	Level 1: All UI Health Care Providers + affiliated providers. Level 2: Blue Access network providers not in Level 1 Level 3: Not covered except in emergencies
ANNUAL DEDUCTIBLE	\$0	\$0	Inpatient hospitalization only, Reference below	Level 1: Single: \$500 Family: \$1,000 Level 2: Single: \$950 Family: \$1,900
COINSURANCE	Reference below	Reference below	Reference below	Reference below
OUT-OF-POCKET MAXIMUM (OPM)	\$4,000 OPM for prescription drugs: N/A	In-network: \$1,700 Out-of-network: \$2,000 total (combined in & out-of-network) OPM for prescription drugs: \$1,100	Levels 1, 2, 3 Participating providers: \$2,000 / \$4,000 Level 3 Non-participating providers: \$2,500 / \$5,000 OPM for prescription drugs: \$1,600 / \$3,200	Level 1: Single: \$2,300 Family: \$4,000 Level 2: Single: \$3,500 Family: \$7,000 OPM for prescription drugs: \$2,000 / \$4,000

	HEALTH ALLIANCE HMO Plus Rx	HEALTH ALLIANCE PPO Plus Rx	WELLMARK BC/BS UIChoice	WELLMARK BC/BS UISelect	
OFFICE VISITS	\$10 copay per primary care physician visit \$35 copay per specialist visit	Primary & Specialty Care: In-network: \$5 copay per visit Out-of-network: 40% coinsurance per visit	Level 1: \$15 copay Level 2: \$30 copay Level 3: 50% coinsurance	Level 1: Primary Care: \$15 copay Specialist: \$25 copay	Level 2: Primary Care: \$40 copay Specialist: \$55 copay
ROUTINE PHYSICALS / PREVENTIVE SERVICES	\$0 copay	In-network: \$0 copay per visit Out-of-network: 40% coinsurance per visit	Level 1, 2, & 3 Participating providers: \$0 copay/coinsurance Level 3 Non-participating providers: 50% coinsurance if office visit; 40% coinsurance if outpatient service	Level 1: \$0 copay Level 2: \$0 copay	
IMAGING & LABS	20% coinsurance per service	In-network: \$5 copay Out-of-network: 10% coinsurance	Level 1: 10% coinsurance Level 2: 20% coinsurance Level 3: 40% coinsurance	Level 1: 15% coinsurance Level 2: 25% coinsurance	
IMMUNIZATIONS	\$0 copay per service *specific vaccines only	In-network: \$0 copay per service Out-of-network: 40% coinsurance per visit	\$0 copay	\$0 copay	
ROUTINE EYE EXAM	Medicare covered: \$0 copay Non-Medicare covered: Not covered	In-network: \$0 copay Out-of-network: 40% coinsurance	Level 1: \$15 copay Level 2: \$30 copay Level 3: 50% coinsurance	Level 1: \$25 copay Level 2: \$55 copay	
ROUTINE HEARING EXAM	\$45 copay for Medicare covered exam; \$45 copay from TruHearing provider for non-Medicare covered test	20% coinsurance for Medicare covered exam; \$45 copay from TruHearing provider non-Medicare covered test	Level 1: \$15 copay Level 2: \$30 copay Level 3: 50% coinsurance	Level 1: \$25 copay Level 2: \$55 copay	
EMERGENCY ROOM CARE	\$90 copay per visit	In & Out-of-network: \$100 copay per visit, (copay waived if admitted)	Level 1, 2, & 3: \$125 copay (waived if admitted) then 10% coinsurance	Level 1, 2 and 3: \$150 copay, then 10% coinsurance (copay waived if admitted)	

	HEALTH ALLIANCE HMO Plus Rx	HEALTH ALLIANCE PPO Plus Rx	WELLMARK BC/BS UIChoice	WELLMARK BC/BS UISelect
ROOM & BOARD	Days 1 – 7: \$280 per day Days 8 & beyond: \$0	In-network: 10% coinsurance Out-of-network: 40% coinsurance	Level 1: \$500 deductible, followed by coinsurance Level 2: \$750 deductible, followed by coinsurance Level 3: \$1,000 deductible, followed by coinsurance	Level 1: \$500 deductible, followed by coinsurance Level 2: \$950 deductible, followed by coinsurance
INPATIENT/OUTPATIENT SURGERY, PHYSICIAN CARE, SUPPLIES, LABS & IMAGING	\$275 copay	In-network: 10% coinsurance Out-of-network: 40% coinsurance	Level 1: 10% coinsurance Level 2: 20% coinsurance Level 3: 40% coinsurance	Level 1: 15% coinsurance Level 2: 25% coinsurance
PRESCRIPTION DRUGS	No Deductible Tier 1: Preferred generic: \$2 copay per prescription Tier 2: Non-preferred generic: \$15 copay Tier 3: Preferred brand drugs: \$47 copay Tier 4: Non-preferred brand: 50% coinsurance Tier 5: Specialty tier: 33% coinsurance No OPM prescriptions	No Deductible Tier 1: Preferred generic: 0% coinsurance Tier 2: Non-preferred generic: 20% coinsurance Tier 3: Preferred brand drugs: 50% coinsurance Tier 4: Non-preferred brand: 50% coinsurance Tier 5: Specialty tier: 50% coinsurance OPM prescriptions: \$1,100	No Deductible Tier 1: Generic drugs: \$0 copay Tier 2: Formulary drugs: Blue Rx Complete 30% coinsurance Tier 3: Non-formulary drugs: 50% coinsurance Tier 4: Name-brand, Non-formulary drugs: 50% coinsurance OPM prescriptions: \$1,600 / \$3,200	No Deductible Tier 1: Generic drugs: \$0 copay Tier 2: Formulary drugs: Blue Rx Value Plus 30% coinsurance Tier 3: Non-formulary drugs: 50% coinsurance Tier 4: Not covered OPM prescriptions: \$2,000 / \$4,000

	HEALTH ALLIANCE HMO Plus Rx	HEALTH ALLIANCE PPO Plus Rx	WELLMARK BC/BS UIChoice	WELLMARK BC/BS UISelect
CHIROPRACTOR	\$20 copay for Medicare covered service	In-network: \$5 copay Out-of-network: 40% coinsurance if Medicare covered	Level 1: No providers Level 2: \$30 copay Level 3: 50% coinsurance	Level 1: No providers Level 2: \$40 copay
HEARING AIDS	Benefits from TruHearing	Benefits from TruHearing	20% coinsurance, maximum benefit of \$1,500 every 36 months	Level 1: 15% coinsurance Level 2: 25% coinsurance maximum benefit of \$1,500 every 36 months
OUTPATIENT PHYSICAL/SPEECH/OCCUPATIONAL & RESPIRATORY THERAPY	\$35 copay per visit	In-network: 10% coinsurance Out-of-network: 40% coinsurance	Level 1 & 2: 10% coinsurance Level 3: 50% coinsurance office, 40% coinsurance facility	Office Level 1: \$15 copay Level 2: \$40 copay Facility Level 1: 15% coinsurance Level 2: 25% coinsurance
HOME HEALTH CARE/HOSPICE CARE	\$0 copay per visit; Medicare-certified Hospice	In-network: 10% coinsurance Out-of-network: 40% coinsurance; Medicare-certified Hospice	Level 1 & 2: 10% coinsurance Level 3: 40% coinsurance	Level 1: 15% coinsurance Level 2: 25% coinsurance
AMBULANCE	\$275 copay per visit	In-network: 10% coinsurance Out-of-network: 40% coinsurance	Level 1 & 2: 10% coinsurance Level 3: 40% coinsurance	15% coinsurance
DURABLE MEDICAL EQUIPMENT	20% coinsurance	In-network: 20% coinsurance Out-of-network: 20% coinsurance	20% coinsurance	Level 1: 15% coinsurance Level 2: 25% coinsurance
OUTPATIENT MENTAL HEALTH	\$40 copay per visit	In-network: 0% coinsurance; 10% coinsurance facility Out-of-network: 40% coinsurance	Level 1 & 2: \$0 copay for office, 10% coinsurance facility Level 3: 50% coinsurance office, 40% coinsurance facility	Office Level 1 and 2: \$0 copay Facility Level 1 and 2: 15% coinsurance

CONTACT INFO:

UICHOICE AND UISELECT

Wellmark: 1-800-643-9724; www.wellmark.com
University Benefits: 319-335-2676; hr.uiowa.edu/benefits

HEALTH ALLIANCE:

Health Alliance Medicare Services at 1-877-917-8550,
TTY 711 or visit healthalliance.org/IA-Retirees

THIS IS ONLY A SUMMARY OF BENEFITS

For additional information, please refer to the applicable Plan Document(s) available online.

Revised 10/16/2023