

# MEDICAL: 2022 PLAN COMPARISON

## IN-NETWORK SERVICES

Health Care Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<b>Preventive Care<sup>1</sup></b>	100% coverage	100% coverage	100% coverage	100% coverage <sup>2</sup>
<b>Eye and Hearing Exam (routine)</b>	100% coverage	100% coverage	100% coverage	100% coverage
<b>Physician<sup>3</sup></b>	\$25 Primary/ \$35 Specialty copay	\$20 Primary/ \$30 Specialty copay	\$40 Primary/ \$50 Specialty copay	90% coverage after deductible
<b>Convenience Clinics/Retail Health Clinics and Virtual Care<sup>4</sup></b>	\$15 copay	\$15 copay	\$20 copay	90% coverage after deductible
<b>Outpatient MRI and CT Scan</b>	\$50 copay	\$40 copay	\$50 copay	90% coverage after deductible
<b>Urgent Care: In-Network and Out-of-Network</b>	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
<b>Emergency Care: In-Network and Out-of-Network</b>	\$100 copay, waived if admitted	\$100 copay, waived if admitted	\$100 copay, waived if admitted	90% coverage after deductible
<b>Outpatient Behavioral Health - Mental Health/ Substance Use Disorder<sup>5</sup></b>	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
<b>Chiropractic Care</b>	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
<b>Physical, Speech, and Occupational Therapy</b>	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible
<b>Home Health Care</b>	\$25 copay	\$20 copay	\$40 copay	90% coverage after deductible

<sup>1</sup> Preventive care includes routine physical, hearing and eye exams; well child care; prenatal care; immunizations; and allergy injections.

<sup>2</sup> HSA guidelines do not view allergy injections as preventive; therefore, the deductible and coinsurance apply to this service.

<sup>3</sup> Primary Care includes Family Medicine, Internal Medicine, Obstetrics/Gynecology, and Pediatrics.

<sup>4</sup> Gopher Quick Clinic in the Twin Cities and other convenience care clinics/retail health clinics; also applies to virtual care.

<sup>5</sup> Outpatient Behavioral Health - Mental Health/Substance Use Disorder virtual care services will apply the office visit benefit.

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## IN-NETWORK AND OUT-OF-NETWORK

Deductibles and Services	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<b>In-Network Deductible<sup>1</sup></b>	\$100 per person/ \$200 per family	\$100 per person/ \$200 per family	\$200 per person/ \$400 per family	Total in-network and out-of-network: Employee only: \$1,500 Family: \$3,000
<b>Out-of-Network Deductible</b>	\$600 per person/ \$1,200 per family	\$600 per person/ \$1,200 per family	\$600 per person/ \$1,200 per family	
<b>Annual Out-of-Pocket Maximum*</b>  Total annual in-network and out-of-network	\$2,500 per person/ \$4,000 per family	\$2,500 per person/ \$4,000 per family	\$2,500 per person/ \$4,000 per family	\$3,000 employee only/ \$6,000 per family  (Note: Out-of-pocket maximums include the deductible)
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Lab/X-Ray</b>	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
<b>Outpatient Surgery</b>	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
<b>In-Network Hospital (General and Behavioral Health - Mental Health/ Substance Use Care)</b>	100% coverage after deductible	100% coverage after deductible	100% coverage after deductible	90% coverage after deductible
<b>Ground and Air Ambulance to Nearest Facility</b>	80% coverage	80% coverage	80% coverage	90% coverage after deductible
<b>Prosthetics, Durable Medical Equipment</b>	80% coverage, including hearing aids	80% coverage, including hearing aids	80% coverage, including hearing aids	90% coverage after deductible, including hearing aids
<b>Out-of-Network Care<sup>2</sup></b>	70% coinsurance after deductible is met, up to the annual out-of- pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum	70% coinsurance after deductible is met, up to the annual out-of-pocket maximum

<sup>1</sup>In-network deductible applies to expenses without a copay, primarily in- and out-patient hospital, and lab/x-ray.

<sup>2</sup>**If you visit an out-of-network provider, Medica discounts do not apply.** That means your out-of-pocket costs can be much higher, potentially thousands of dollars. Plus, Medica usually pays out-of-network providers less than the amount they bill. When this happens, you're responsible for paying the provider the balance.

# MEDICAL: 2022 PLAN COMPARISON

## PRESCRIPTION DRUGS

The UPlan Pharmacy program is provided through Prime Therapeutics and Fairview Specialty Pharmacy. It is automatically provided to members in all UPlan medical options.

A prescription is dispensed as a 30-day supply (including insulin) in network pharmacies only.

Prescription Drug Categories	Base Plan Medica Elect/ Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<b>Certain Preventive Medications Specified in the Affordable Care Act and Contraceptives in the Generic Plus Category</b>	\$0 copay	\$0 copay	\$0 copay	100%
<b>Generic Plus (Tier 1) Drugs</b> (includes covered generic drugs and some low-cost brand drugs if there is no covered generic drug in a given therapeutic class.)	\$10 copay	\$10 copay	\$10 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
<b>Formulary Brand Name (Tier 2) Drugs</b> (includes other covered formulary brand drugs)	\$30 copay	\$30 copay	\$30 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
<b>Non-formulary (Tier 3) Drugs</b> (includes covered brand drugs not listed on formulary)	\$75 copay	\$75 copay	\$75 copay	Prescriptions are covered in the HSA and at 90% in medical plan after deductible
<b>Purchase of Brand Drug When Chemically Equivalent Generic is Available</b>	Pay the <b>generic copay and difference in cost<sup>1</sup></b> between the brand drug and the generic drug	Pay the <b>generic copay and difference in cost<sup>1</sup></b> between the brand drug and the generic drug	Pay the <b>generic copay and difference in cost<sup>1</sup></b> between the brand drug and the generic drug	Prescriptions are covered in the HSA and at 90% in medical plan after deductible <sup>2</sup>
<b>Drugs Purchased by Mail Order</b>	3-month supply available for two copays	3-month supply available for two copays	3-month supply available for two copays	90-day supply available at discount
<b>Annual Out-of-Pocket Maximum (Rx only)</b>	\$750 per person/ \$1,500 per family	\$750 per person/ \$1,500 per family	\$750 per person/ \$1,500 per family	No separate out-of-pocket maximum for prescriptions

<sup>1</sup> The difference in cost does not apply toward the annual out-of-pocket maximum.

<sup>2</sup> When in the coinsurance level, pay 10 percent coinsurance based on generic price in addition to difference in cost between the brand drug and the generic drug.

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## OTHER COVERAGE AND MAXIMUMS

Other Coverage and Maximums	Base Plan Medica Elect/Essential Medica Choice Regional	Medica ACO Plan	Medica Choice National	Medica HSA
<b>Travel Benefit: In-Network Coverage</b>	For students and other travelers if services are provided by United Healthcare Options PPO providers	For students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers	For out-of-area residents, students and other travelers if services are provided by United Healthcare Options PPO providers
<b>National Coverage</b>	Available through emergency or out-of-network benefit only	Available through emergency or out-of-network benefit only	Available in-network through United Healthcare Options PPO network	Available in-network through United Healthcare Options PPO network

\*If you go out of network, you could end up paying more than the out-of-pocket maximum, because certain amounts you pay don't count toward the maximum. Plus, even after you've met your out-of-pocket maximum, you'll continue to pay the difference between what the provider bills and what Medica pays.

Annual HSA Contributions	UPlan Contribution	Employee Maximum Contribution	Total Annual Contribution
Employee-only amount	\$750	\$2,900	\$3,650
Family coverage amount (either tier)	\$1,500	\$5,800	\$7,300
Catch-up amount - Age 55 or over		\$1,000	2022 max + \$1,000 catch-up

# MEDICAL: 2022 UPLAN BIWEEKLY RATES

## EMPLOYEE-ONLY

Plans	Wellbeing Rates		Standard Rates		Total Cost
	Employee	University	Employee	University	
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	\$28.96	\$341.71	\$48.19	\$322.48	\$370.67
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	\$9.83	\$341.71	\$29.06	\$322.48	\$351.54
Medica Choice National	\$113.69	\$341.71	\$132.92	\$322.48	\$455.40
Medica HSA	\$22.71	\$341.71	\$41.94	\$322.48	\$364.42

## EMPLOYEE AND CHILDREN

Plans	Wellbeing Rates		Standard Rates		Total Cost
	Employee	University	Employee	University	
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	\$106.01	\$536.23	\$125.24	\$517.00	\$642.24
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	\$71.55	\$536.23	\$90.78	\$517.00	\$607.78
Medica Choice National	\$252.13	\$536.23	\$271.36	\$517.00	\$788.36
Medica HSA	\$95.32	\$536.23	\$114.55	\$517.00	\$631.55

## EMPLOYEE AND SPOUSE WITH OR WITHOUT CHILDREN

Plans	Wellbeing Rates		Standard Rates		Total Cost
	Employee	University	Employee	University	
Medica Elect/Essential: Twin Cities & Duluth Base Plan Medica Choice Regional: Greater Minnesota Base Plan	\$158.58	\$802.60	\$187.43	\$773.75	\$961.18
Medica ACO Plan: Crookston area, Duluth area & parts of northeastern Minnesota, Rochester area, Twin Cities metro area	\$108.89	\$802.60	\$137.74	\$773.75	\$911.49
Medica Choice National	\$377.78	\$802.60	\$406.63	\$773.75	\$1180.38
Medica HSA	\$141.69	\$802.60	\$170.54	\$773.75	\$944.29

- Total Costs are for those with a 50% to 74% time appointment
- Employees who work 50% to 74% time will pay the “Total Cost” rate per pay period
- Employees who earned the \$500/\$750 Wellbeing reduction in 2020-21 pay the Wellbeing Program Rate in 2022. Those who didn’t earn the wellbeing points will pay the Standard Rate.