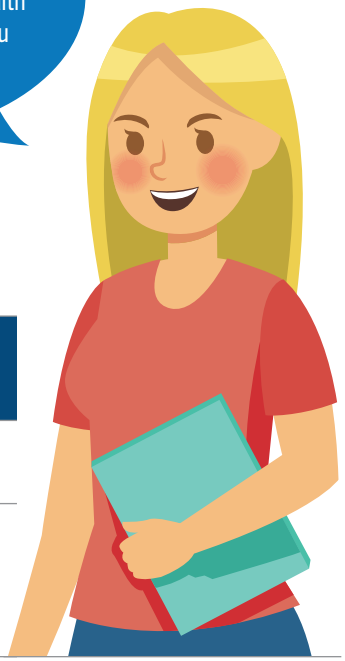
Compare your coverage options
MIIP HEALTH CARE PLANS

PLANS EFFECTIVE 7/1/22 – 6/30/23

NEW IN 2022!
During your annual enrollment period, you may enroll in any health plan offered by MIIP, even if you previously waived coverage.



PLAN COSTS	HMO ESSENTIAL *Coverage in Iowa only*	PPO CHOICE *Nationwide coverage*	PPO PREMIER *Nationwide coverage*
ANNUAL DEDUCTIBLE	Single $2,000 // Family $4,000	Single $1,250 // Family $2,500	Single $750 // Family $1,500
OUT-OF-POCKET MAXIMUM (OPM): MEDICAL	Single $4,000 // Family $8,000 *Medical and pharmacy OPMs are **two separate amounts.** See page 5 for pharmacy OPM.*	Single $3,500 // Family $7,000 *Medical and pharmacy OPMs are **two separate amounts.** See page 5 for pharmacy OPM.*	Single $2,500 // Family $5,000 *Medical and pharmacy OPMs are **two separate amounts.** See page 5 for pharmacy OPM.*

"DO I HAVE TO MEET MY FULL DEDUCTIBLE BEFORE MY PLAN PAYS?"

If you stay in-network, **you won't have to meet your deductible for many common health care services**. You'll pay nothing for preventive care and for Doctor On Demand® visits, and you'll only owe a copay for ...

- Office visits
- Telehealth appointments
- Chiropractic care

However, you will have to meet your deductible before your plan pays benefits for ...

- Emergency room care
- Inpatient or outpatient hospital care
- Skilled nursing care
- Home health care or medical equipment

See the charts on the following pages or visit Wellmark.com for details.

GLOSSARY

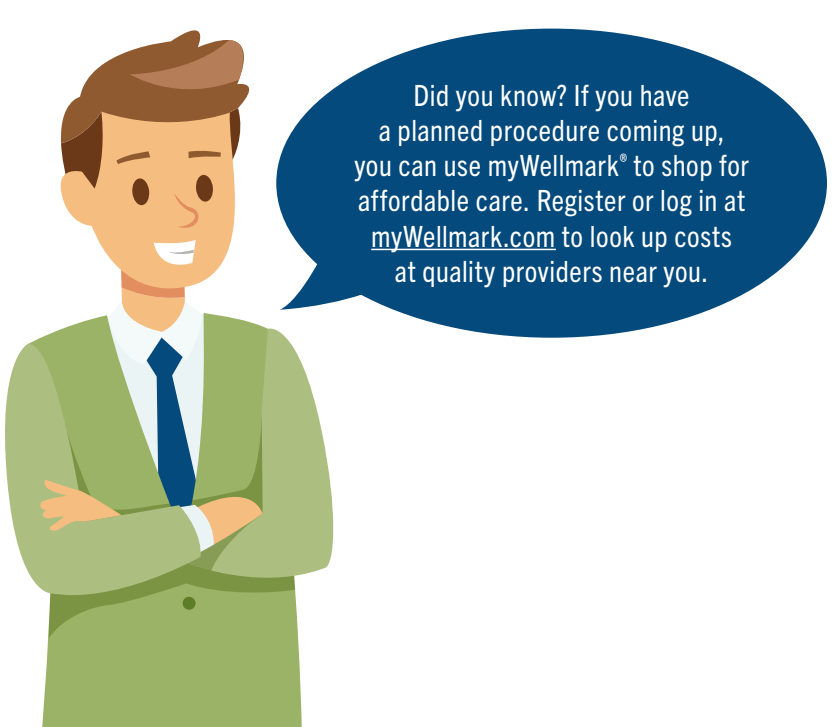
DEDUCTIBLE
The amount you pay for some covered services before your plan begins to pay benefits.

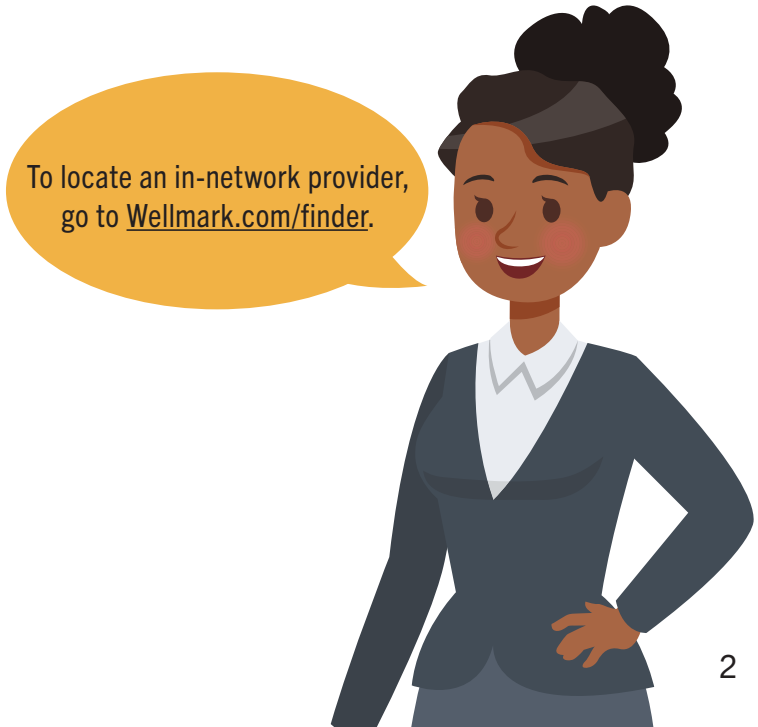
COINSURANCE
A percentage of the cost you pay each time you receive certain kinds of care.

COPAY
A flat dollar amount you pay each time you receive certain kinds of care.
With MIIP coverage, services subject to copays are not subject to the deductible.

OUT-OF-POCKET MAXIMUM (OPM)
The most you will pay for services in a calendar year.

WHERE YOU CAN GET CARE	HMO ESSENTIAL *Coverage in Iowa only*	PPO CHOICE *Nationwide coverage*	PPO PREMIER *Nationwide coverage*
NETWORK	Blue Access® network	Alliance Select℠ network	
PROVIDER CHOICE	You are not required to designate a primary care physician. You may see any provider in the Blue Access network. No referrals are required. If you go out of network, your care will not be covered, and you will pay the full cost.	You are not required to designate a primary care physician. You may see any provider you choose. No referrals are required. You will pay less out of pocket if you go to an in-network Alliance Select provider.	
WHERE IS CARE COVERED?	**IN IOWA:** Care is covered at in-network providers across Iowa and in some surrounding counties. **OUTSIDE OF IOWA:** Emergency care is covered out of state. For non-emergencies, only care from Doctor On Demand is covered. **LONG-TERM TRAVEL:** Dependent children attending college, long-term travelers, and families living apart may be covered through guest memberships. Call the customer service number on the back of your Wellmark ID for information about guest memberships.	**WORLDWIDE:** Care is covered at in-network and out-of-network providers in Iowa, as well as across the U.S. and around the world. **CARE WHILE TRAVELING:** If you need care when traveling and you receive services from a physician or hospital designated as a BlueCard PPO® provider, you'll be covered by benefits based on the local Blue plan's negotiated rates.	





COST SHARE DETAILS

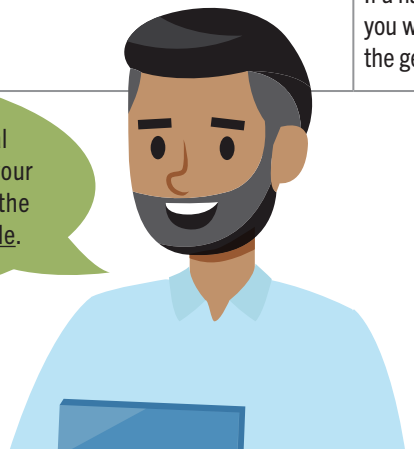
	HMO ESSENTIAL *Coverage in Iowa only*	PPO CHOICE *Nationwide coverage*		PPO PREMIER *Nationwide coverage*	
		IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
PREVENTIVE CARE Routine and diagnostic care including: annual physical, annual ob/gyn exam, pap smear, well-child care up to age 7, immunizations, mammogram, breast imaging ultrasound, sigmoidoscopy, colonoscopy and psa tests.	No cost to you	No cost to you	Deductible then 30% coinsurance	No cost to you	Deductible then 20% coinsurance
OFFICE CARE	$35 copay	$25 copay	Deductible then 30% coinsurance	$20 copay	Deductible then 20% coinsurance
DOCTOR ON DEMAND For prescriptions, member cost share applies.	No cost to you	No cost to you		No cost to you	
TELEHEALTH For prescriptions, member cost share applies.	$35 copay	$25 copay	Deductible then 30% coinsurance	$20 copay	Deductible then 20% coinsurance
INDEPENDENT LAB & X-RAY	$35 copay	20% coinsurance	Deductible then 30% coinsurance	10% coinsurance	Deductible then 20% coinsurance
CHIROPRACTIC CARE	$35 copay	$25 copay	Deductible then 30% coinsurance	$20 copay	Deductible then 20% coinsurance
EMERGENCY ROOM In an emergency situation, if you cannot reasonably reach an in-network provider, covered services will be reimbursed as though they were received from an in-network provider.	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance
INPATIENT OR OUTPATIENT HOSPITAL CARE	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance

COST SHARE DETAILS (CONT.)	HMO ESSENTIAL *Coverage in Iowa only*	PPO CHOICE *Nationwide coverage*		PPO PREMIER *Nationwide coverage*	
		IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
MATERNITY	Deductible then 25% coinsurance Routine prenatal and postnatal office visits for the mother's care are 100% covered.	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance
ALLERGY SERVICES, IN-OFFICE Includes shots, testing and serum.	$35 copay	$25 copay	Deductible then 30% coinsurance	$20 copay	Deductible then 20% coinsurance
INFERTILITY Covers transfer procedures only, to a $15,000 lifetime maximum.	Office visit: $35 copay Outpatient/inpatient care: Deductible then 25% coinsurance	Office visit: $25 copay Outpatient/inpatient care: Deductible then 20% coinsurance	Deductible then 30% coinsurance	Office visit: $20 copay Outpatient/inpatient care: Deductible then 10% coinsurance	Deductible then 20% coinsurance
MENTAL HEALTH & CHEMICAL DEPENDENCY CARE	Doctor On Demand visits: No cost to you Office/telehealth visits: $35 copay Outpatient/inpatient care: Deductible then 25% coinsurance	Doctor On Demand visits: No cost to you Office/telehealth visits: $25 copay Outpatient/inpatient care: Deductible then 20% coinsurance	Telehealth visits, office visits, outpatient and inpatient care: Deductible then 30% coinsurance	Doctor On Demand visits: No cost to you Office/telehealth visits: $20 copay Outpatient/inpatient care: Deductible then 10% coinsurance	Telehealth visits, office visits, outpatient and inpatient care: Deductible then 20% coinsurance
SKILLED NURSING	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance
VISION One annual routine vision exam at an in-network eye doctor.	Vision benefits are available under Vision Service Plan, which includes a routine eye exam with a $10 copayment. See your Vision Service Plan (VSP) Benefit Summary for coverage details. The HMO Essential Plan offers one routine annual exam that may be used in addition to VSP with a $35 copayment; however the HMO plan does not provide a benefit for glass and/or contacts.				
OTHER COVERED SERVICES Home health visit*, home infusion therapy*, private duty nursing*, home/durable medical equipment, oxygen and equipment. **Precertification required*	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance

PRESCRIPTION DRUG COVERAGE

		HMO ESSENTIAL *Iowa only*	PPO CHOICE *Nationwide*	PPO PREMIER *Nationwide*
		BLUE RX COMPLETE℠		
DRUG COSTS Your drug's tier determines how much you'll pay at the pharmacy. The lower the tier, the more affordable your prescription.	**TIER 1:** Most affordable drugs Includes most generics and select name-brand drugs.	$10		
	TIER 2: Preferred drugs Drugs that are proven to be effective and favorably priced compared to other drugs that treat the same condition.	$40		
	TIER 3: Non-preferred drugs Drugs that have not been found to be any more effective than available generics or preferred brands.	$70		
	TIER 4: Limited-value drugs Combination products, lifestyle drugs or drugs with more cost-effective options available on lower tiers.	$100		
SPECIALTY DRUGS Specialty drugs are high-cost medications for complex conditions that require special handling. You may only fill prescriptions for specialty drugs at CVS Specialty® Pharmacies. Learn more and locate a pharmacy at CVSspecialty.com.	**PREFERRED BIOSIMILAR/ GENERIC SPECIALTY DRUGS**	$25		
	PREFERRED SPECIALTY DRUGS	$50		
	NON-PREFERRED SPECIALTY DRUGS	$200		
OUT-OF-POCKET MAXIMUM (OPM): PHARMACY		Single: $2,600 // Family: $5,200 *Medical and pharmacy OPMs are two separate amounts. See page 1 for medical OPM.*		
QUANTITY LIMITS	**RETAIL**	TIER 1: Up to a 90-day supply (3 copays)		
		TIERS 2, 3 and 4: Up to a 30-day supply (1 copay)		
	MAIL ORDER	TIERS 1, 2, 3 and 4: Up to a 90-day supply (2 copays)		
PRODUCT SELECTION PENALTY RULE		If a name-brand drug is dispensed when a generic is available, you will pay a penalty: your cost share, plus the difference between the generic drug and the name-brand drug.		

Use the CVS Caremark® member portal and app to access savings and manage your pharmacy benefits. Register and link to the free mobile app at Caremark.com/mobile.



ABOUT THIS GUIDE The benefits information presented in this book describes only the highlights of the plans and does not constitute official plan documents. Additional terms and conditions apply. If there are any discrepancies between the information contained herein and the official plan documents, the plan documents will govern.

YOUR HEALTH AND RX BENEFITS ADMINISTRATOR

Wellmark®

Customer Service: 1-800-277-8380 | Wellmark.com

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the certificate itself and enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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