Kirkwood Community College

MIIP Health Care Plans

Compare your coverage options.

Did you know? During your annual enrollment period, you may enroll in any health plan offered by MIIP, even if you previously waived coverage.

Plans effective 7/1/26 - 6/30/27

Plan costs

	HDHP Value	HMO Core	PPO Core	PPO Choice
Network/coverage	Blue POS℠/Nationwide	Blue HMO℠/Iowa only	Blue PPO℠/Nationwide	Blue PPO/Nationwide
Annual deductible	In network: Single $5,000 Family $10,000 Out of network: Single $10,000 Family $20,000	Single $3,000 Family $6,000	Single $2,000 Family $4,000	Single $1,250 Family $2,500
	Medical and pharmacy deductibles are combined into one amount.			
Out-of-pocket maximum (OPM): Medical	In network: Single $5,000 Family $10,000 Out of network: Single $20,000 Family $40,000	Single $6,000 Family $12,000	Single $4,000 Family $8,000	Single $3,500 Family $7,000
	Medical and pharmacy OPMs are combined into one amount.	Medical and pharmacy OPMs are two separate amounts. See **page 7** for pharmacy OPM.		
Qualifies you to open a health savings account (HSA)	Yes	No	No	No

IMPORTANT: Members newly enrolling in the HDHP Value or HMO Core plans must select a primary care provider (PCP). If you don't choose a PCP, one will be assigned to you (based on your recent visit history and/or proximity to the home address Wellmark has on file for you). You'll be notified via mail when this auto assignment occurs.

"Do I have to meet my full deductible before my plan pays?"

On all MIIP health plans you pay $0 for …

- In-network **ACA preventive care**
- **Doctor On Demand**® by Included Health telehealth visits*

On the HDHP Value plan …

You'll owe the full cost of care until you reach your deductible, which is also your annual out-of-pocket maximum.

On the HMO Core and PPO plans …

If you stay in network, you won't have to meet your deductible for many common health care services. 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

To learn more, see the charts on the following pages.

* Member cost share applies to prescriptions.

Understanding the HDHP Value plan

The HDHP Value plan is a high-deductible health plan that provides coverage both in Iowa and nationwide. Here are some additional features of the HDHP Value plan:

Lower premium; higher deductible

You'll pay the full cost for care until you meet your deductible, except with **ACA preventive care** and Doctor On Demand virtual care which is 100% covered.*

Out-of-network-coverage

Out-of-network care is covered, but you'll pay the highest out-of-pocket cost — and you may be balance billed, or charged for the difference between your bill amount and what insurance covers, if you receive care from a non-partcipating provider.

Unique OPM

On this plan, the in-network deductible is the same as your out-of-pocket maximum. That means, once you reach your deductible, your plan pays 100% of your covered costs.

Qualifies you to open an HSA

A health savings account (HSA) has triple-tax advantages. You can use your account to pay for care now, to save for more expensive procedures later, or even to supplement your retirement.

What's an HSA?

To compensate for the higher deductible, MIIP members who elect the HDHP Value plan may be eligible to open and contribute to this unique savings account. (See some of the top benefits listed to the right.)

High-deductible health plans are not for everyone. But if you are willing to plan ahead, track your spending and pay more up front for care, the HDHP Value plan may be a good choice that helps you save long term.

* Member cost share applies to prescriptions.

"Why should I get an HSA?"

There are many reasons someone may choose to open an HSA — here's the top four most popular benefits:

1. With an HSA, you can set aside money to pay for qualified medical, prescription, dental and vision care expenses.
2. Your employer may contribute to your HSA.
3. Your personal contributions are made pre-tax, you'll enjoy tax-free interest and investment earnings, and you won't be taxed when you use the funds for qualified purchases.
4. Your HSA rolls over each year. It's yours to keep, even if you change jobs or retire.

Remember!
Members enrolled in the HDHP Value plan must select a primary care provider (PCP), which can be done easily through myWellmark®.

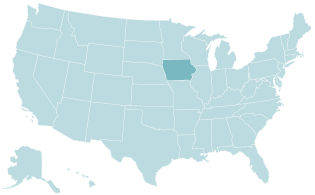
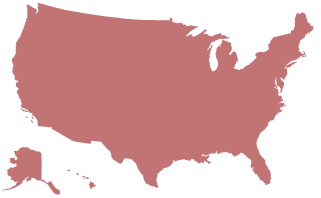
"Did you know?"

With a myWellmark account you can select a primary care provider, shop for affordable care, stay up to date with your claims status, and more.

To register or log in, visit **myWellmark.com**.

Note: Some facilities use provider-based billing which may result in additional out-of-pocket costs. When scheduling care, ask if there are any additional department, clinic or facility fees that will be billed separately with the visit.

Where you can get care

PLAN	HDHP Value	HMO Core	PPO Core or PPO Choice
			
COVERAGE	**Iowa & Nationwide** In-network care is covered within Iowa and some surrounding counties. Out-of-network care in Iowa and nationwide is also covered but you will pay higher out-of-pocket costs. Emergency care is also covered nationwide. Dependent children in 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 more information.	**Iowa only** In-network care is covered within Iowa and some surrounding counties. Emergency care is covered out of state. For non-emergency care out of state, only Doctor On Demand is covered. Dependent children in 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 more information.	**Worldwide** Care is covered at in-network and out-of-network providers in Iowa, as well as nationwide, and around the world. If you need care when traveling and you receive services from a physician or hospital designated as a BlueCard® PPO provider, you will be covered by benefits based on the local Blue plan's negotiated rates.
NETWORK	**Blue POS network** You are required to designate a primary care physician. You may see any provider in the Blue POS network. No referrals are required. Both in-network and out-of-network care are covered; however, you will pay higher out-of-pocket costs for out-of-network care.	**Blue HMO network** You are required to designate a primary care physician. You may see any provider in the Blue HMO network. No referrals are required. If you go out of network, your care will not be covered, and you will pay for the full cost of your care.	**Blue PPO network** 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 Wellmark Blue PPO provider.

To locate an in-network provider, go to **Wellmark.com/Find-Care**.

"What is covered?"

ACA 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.

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.

To locate in-network providers near you, vist **Wellmark.com/Find-Care**. Click find a provider and type in your plan's prefix when prompted.

PPO: *RDP;* HMO/POS: *XQW*

Cost share details

<table>
<tr><th></th><th colspan="2">HDHP Value</th><th colspan="2">HMO Core</th><th colspan="2">PPO Core</th><th colspan="2">PPO Choice</th></tr>
<tr><td rowspan="2">Network/ coverage</td><td colspan="2">Blue POS/Nationwide</td><td colspan="2">Blue HMO/Iowa only</td><td colspan="2">Blue PPO/Nationwide</td><td colspan="2">Blue PPO/Nationwide</td></tr>
<tr><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td></tr>
<tr><td>Preventive care</td><td>No cost to you</td><td>Out-of-network deductible applies, then 25% coinsurance.</td><td>No cost to you</td><td>Not covered</td><td>No cost to you</td><td>Deductible then 40% coinsurance</td><td>No cost to you</td><td>Deductible then 30% coinsurance</td></tr>
<tr><td>Doctor On Demand*</td><td colspan="8">No cost to you</td></tr>
<tr><td>Office care</td><td rowspan="6">You pay the full negotiated cost for care until you have met your deductible/OPM.</td><td rowspan="6">Out-of-network deductible applies, then 25% coinsurance.</td><td>$35 PCP; $50 all other</td><td rowspan="6">Not covered</td><td>$35 copay</td><td rowspan="6">Deductible then 40% coinsurance</td><td>$25 copay</td><td rowspan="6">Deductible then 30% coinsurance</td></tr>
<tr><td>Telehealth*</td><td rowspan="3">$35 copay</td><td>$35 copay</td><td>$25 copay</td></tr>
<tr><td>Independent lab and X-ray</td><td>20% coinsurance</td><td>20% coinsurance</td></tr>
<tr><td>Chiropractic care</td><td>$35 copay</td><td>$25 copay</td></tr>
<tr><td>Emergency room</td><td rowspan="2">Deductible then 25% coinsurance</td><td rowspan="2">Deductible then 20% coinsurance</td><td rowspan="2">Deductible then 20% coinsurance</td></tr>
<tr><td>Inpatient or outpatient hospital care</td></tr>
</table>

*For prescriptions, member cost share applies.

Cost share details, continued

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<tr><th></th><th colspan="2">HDHP Value</th><th colspan="2">HMO Core</th><th colspan="2">PPO Core</th><th colspan="2">PPO Choice</th></tr>
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<tr><td></td><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td><td>IN NETWORK</td><td>OUT OF NETWORK</td></tr>
<tr><td>Maternity</td><td rowspan="5">You pay the full negotiated cost for care until you have met your deductible/OPM.</td><td rowspan="5">Out-of-network deductible applies, then 25% coinsurance.</td><td>Deductible then 25% coinsurance

Routine prenatal and postnatal office visits for the mother's care are 100% covered.</td><td rowspan="5">Not covered</td><td>Deductible then 20% coinsurance</td><td>Deductible then 40% coinsurance</td><td>Deductible then 20% coinsurance</td><td>Deductible then 30% coinsurance</td></tr>
<tr><td>Allergy services, in-office
Includes shots, testing and serum.</td><td>$35 copay</td><td>$35 copay</td><td>Deductible then 40% coinsurance</td><td>$25 copay</td><td>Deductible then 30% coinsurance</td></tr>
<tr><td rowspan="2">Infertility
Covers transfer procedures only, up to a $15,000 lifetime maximum.</td><td>Office visit: $35/$50 copay</td><td>Office visit: $35 copay</td><td rowspan="2">Deductible then 40% coinsurance</td><td>Office visit: $25 copay</td><td rowspan="2">Deductible then 30% coinsurance</td></tr>
<tr><td>Outpatient/ inpatient care: Deductible then 25% coinsurance</td><td>Outpatient/ inpatient care: Deductible then 20% coinsurance</td><td>Outpatient/ inpatient care: Deductible then 20% coinsurance</td></tr>
<tr><td></td><td colspan="8">Doctor On Demand visits: No cost to you*</td></tr>
<tr><td>Mental health & chemical dependency care</td><td rowspan="4">You pay the full negotiated cost for care until you have met your deductible/OPM.</td><td rowspan="4">Out-of-network deductible applies, then 25% coinsurance.</td><td>Office/telehealth visits: $35 copay</td><td rowspan="4">Not covered</td><td>Office/telehealth visits: $35 copay</td><td rowspan="2">Telehealth visits, office visits, outpatient and inpatient care: Deductible then 40% coinsurance</td><td>Office/telehealth visits: $25 copay</td><td rowspan="2">Telehealth visits, office visits, outpatient and inpatient care: Deductible then 30% coinsurance</td></tr>
<tr><td>Outpatient/ inpatient care: Deductible then 25% coinsurance</td><td>Outpatient/ inpatient care: Deductible then 20% coinsurance</td><td>Outpatient/ inpatient care: Deductible then 20% coinsurance</td></tr>
<tr><td>Skilled nursing</td><td>Deductible then 25% coinsurance</td><td>Deductible then 20% coinsurance</td><td>Deductible then 40% coinsurance</td><td>Deductible then 20% coinsurance</td><td>Deductible then 30% coinsurance</td></tr>
<tr><td>Vision
One annual routine vision exam at an in-network eye doctor.</td><td>$35 copay</td><td colspan="4">Not a covered benefit</td></tr>
<tr><td>Other covered services**</td><td>Deductible then 25% coinsurance</td><td>Deductible then 20% coinsurance</td><td>Deductible then 40% coinsurance</td><td>Deductible then 20% coinsurance</td><td>Deductible then 30% coinsurance</td></tr>
</table>

* Member cost share applies to prescriptions.

**Home health visit, home infusion therapy, private duty nursing (precertification required); home/durable medical equipment, oxygen and equipment.

Prescription drug coverage

		HDHP Value	HMO Core	PPO Core	PPO Choice
Network/coverage		Blue POS/ Nationwide	Blue HMO/ Iowa only	Blue PPO/ Nationwide	Blue PPO/ Nationwide
		Blue Rx Complete℠			
Drug costs	Tier 1	You pay the full negotiated cost until you have met your deductible/OPM.	$10		$10
	Tier 2		$50		$40
	Tier 3		$100		$70
	Tier 4		$150		$100
Specialty drugs	Preferred biosimilar/ generic	You pay the full negotiated cost until you have met your deductible/OPM.	$25		$25
	Preferred		$75		$50
	Non-preferred		$250		$200
Out-of-pocket maximum (OPM): Pharmacy		See **page 2** for OPM. Medical and pharmacy OPMs are combined into one amount.	Single: $3,000 Family: $6,000		Single: $2,600 Family: $5,200
			Medical and pharmacy OPMs are two separate amounts. See **page 2** for medical OPM.		
Quantity limits	Retail: Tier 1	Up to a 90-day supply (deductible)	Up to a 90-day supply (3 copays)		
	Retail: Tiers 2, 3 & 4	Up to a 30-day supply (deductible)	Up to a 30-day supply (1 copay)		
	Mail order: all medications	Up to a 90-day supply (deductible)	Up to a 90-day supply (3 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**.

"What is the difference between tiers?"

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.

Tier 2: Preferred drugs

Drugs that are proven to be effective and favorably priced compared to other drugs that treat the same condition.

Tier 3: Non-preferred drugs

Drugs that have not been found to be any more effective than available generics or preferred brands.

Tier 4: Limited-value drugs

Combination products, lifestyle drugs or drugs with more cost-effective options available on lower tiers.

"What is a specialty drug?"

Specialty drugs are high-cost medications for complex conditions that require special handling. Specialty drugs must be obtained at a pharmacy that participates in the Iowa Any Willing Provider Specialty Pharmacy Network.

"What's *that* mean?"

In network/Out of network

In-network health care providers have contracted with Wellmark to accept discounted rates. Out-of-network providers have not agreed to the discounted rates. You will pay much less at in-network doctors, hospitals and pharmacies.

Premium

The amount taken from each paycheck to pay for your health insurance coverage.

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 covered services in a calendar year.

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 benefits are provided by the **Metro Interagency Insurance Program (MIIP)**, and administered by **Wellmark Blue Cross and Blue Shield**.

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.

Member cost share applies to prescriptions. Doctor On Demand physicians do not prescribe Scheduled I-IV DEA Controlled Substances and may elect not to treat or prescribe other medications based on what is clinically appropriate. During times of high overnight call volume, patients may be directed to make an appointment with a Doctor On Demand physician for the following morning.

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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