Compare your coverage options

MIIP HEALTH CARE PLANS

EFFECTIVE 7/1/20 – 6/30/21

PLAN BASICS

	HMO ESSENTIAL *(Coverage in Iowa only)*	**PPO CHOICE** *(Nationwide coverage)*	**PPO PREMIER** *(Nationwide coverage)*
OFFICE CARE	$35 copay Applies once per provider per date of service.	$25 copay Applies per date of service.	$20 copay Applies per date of service.
ANNUAL DEDUCTIBLE Services subject to copays are not subject to the 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 Pharmacy coverage has a separate OPM. See page 5 for details.	Single $4,000 Family: $8,000	Single $3,500 Family $7,000	Single $2,500 Family $5,000

GLOSSARY

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

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.

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

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

NETWORK

	HMO ESSENTIAL *(Coverage in Iowa only)*	**PPO CHOICE** *(Nationwide coverage)*	**PPO PREMIER** *(Nationwide coverage)*
NETWORK	Blue Access® network	Alliance Select℠ network	Alliance Select network
PROVIDER CHOICE	Members must use providers in the Blue Access network. If you go out of network, your care will not be covered, and you will pay the full cost. ***NEW!*** **Members are not required to designate a primary care physician (PCP).**	Members may go to any provider they choose. You will pay less out of pocket if you go to an in-network Alliance Select PPO 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.	Care is covered anywhere in the world via the BlueCard® PPO program. 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.	

If you do not currently have health insurance through MIIP, during the annual enrollment period, you may only select the HMO Essential plan for coverage.

To locate an in-network provider, go to Wellmark.com/finder.

YOUR COST SHARE

	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.	$0 copay	$0 copay	Deductible then 30% coinsurance	$0 copay	Deductible then 20% coinsurance
OFFICE CARE	$35 copay Applies once per provider per date of service.	$25 copay Applies per date of service.	Deductible then 30% coinsurance Applies per date of service.	$20 copay Applies per date of service.	Deductible then 20% coinsurance Applies per date of service.
DOCTOR ON DEMAND For prescriptions, member cost share applies.	$0 copay	$0 copay		$0 copay	
INDEPENDENT LAB & X-RAY	$35 copay Applies once per provider per date of service.	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	Deductible then 25% coinsurance In an emergency situation, if you cannot reasonably reach a Wellmark Blue HMO provider, covered services will be reimbursed as though they were received from a Wellmark Blue HMO provider.	Deductible then 20% coinsurance	Deductible then 30% coinsurance In an emergency situation, if you cannot reasonably reach an in-network PPO provider, covered services will be reimbursed as though they were received from an in-network PPO provider.	Deductible then 10% coinsurance	Deductible then 20% coinsurance In an emergency situation, if you cannot reasonably reach an in-network PPO provider, covered services will be reimbursed as though they were received from an in-network PPO provider.
INPATIENT HOSPITAL CARE	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance
OUTPATIENT HOSPITAL CARE	Deductible then 25% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Deductible then 10% coinsurance	Deductible then 20% coinsurance

YOUR COST SHARE (CONTINUED)

	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 care 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 Transfer procedures up to $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	Office visit: $35 copay Doctor On Demand/telehealth services: $0 copay Outpatient/inpatient care: Deductible then 25% coinsurance	Office visit: $25 copay Doctor On Demand/ telehealth services: $0 copay Outpatient/inpatient care: Deductible then 20% coinsurance	Deductible then 30% coinsurance	Office visit: $20 copay Doctor On Demand/ telehealth services: $0 copay Outpatient/inpatient care: Deductible then 10% coinsurance	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	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

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 SPECIALTY DRUGS** $50		**NON-PREFERRED SPECIALTY DRUGS** $200	
OUT-OF-POCKET MAXIMUM (OPM): PHARMACY Medical coverage has a separate OPM. See page 1 for details.	Single $2,600 Family $5,200			
QUANTITY LIMITS	**RETAIL: TIER 1** Up to a 90-day supply (3 copays)	**RETAIL: TIERS 2, 3 and 4** Up to a 30-day supply (1 copay)	**MAIL ORDER: ALL MEDICATIONS** 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.			

The HMO ESSENTIAL, PPO CHOICE and PPO PREMIER plans all have the same prescription drug coverage with BLUE Rx COMPLETE.

YOUR HEALTH AND RX BENEFITS ADMINISTRATOR

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. (Updated 02/25/2020)

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

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线： 888-781-4262）。

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

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