The benefits in this guide are subject to change each year. Participants are responsible for understanding and reviewing benefits.
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What do I need to do?

☐ Review the entire Enrollment Guide.

☐ Add family members to your health and/or dental benefits or change plans by the assigned deadline, which is included in the welcome letter. Failure to enroll family in benefits or change plans within 31 days, will require you to wait until the next open change period.

☐ Keep your benefits current. You are responsible to promptly notify University Human Resources – Benefits Office of any family status changes (see Page 11).
Welcome to the Iowa State University Benefit Program!

The University Human Resources, Benefits Office welcomes you as a Pre/Post-Doctoral Associate of Iowa State University.

The University Human Resources, Service Center is located in 3810 Beardshear Hall. This is where you turn in enrollment forms or check in if you have an appointment with the Benefits Office Staff.

The telephone number is 515-294-4800 / 877-477-1485, the fax number is 515-294-4707, and the e-mail address is benefits@iastate.edu. The office is open from 8:00 a.m. to 5:00 p.m. Monday through Friday except during holidays or when the University is operating under reduced hours. Any alteration of office hours will be posted as well as indicated on the voice messaging system.

The benefits staff is available to assist you and answer benefit questions. Drop-ins are welcome, but appointments are preferred to ensure the benefits staff is available to meet with you.

To speak with a consultant regarding the Iowa State University Benefits program, please call 515-294-4800 / 877-477-7485 to schedule an appointment.

Iowa State University provides Pre/ Post-Doctoral Associates with various kinds of insurance protection and group supplemental retirement plans. Some are automatic or mandated by law. In some cases the University contributes towards the cost of these programs or bears it entirely.

This booklet is designed to provide you with an overview of the benefit programs to assist you in making enrollment decisions. This booklet is not intended to be a policy statement. When you enroll, you will have online access to policy booklets and/or certificates of coverage, which will be your full policy statement.

Automatic Enrollment:

As a Pre/Post-Doctoral Associate you are automatically enrolled in the following insurance plans:

Health/Prescription Drug:
- Wellmark BC/BS Alliance Select - ISU Plan PPO
- Express Scripts
- Yourself only coverage

Dental:
- Delta Dental of Iowa – ISU Plan Basic
- Yourself only coverage

- Family Members:

If you wish to add a spouse/domestic partner or children to your plan you must complete an Enrollment form.
• **Deadline Date:**

You will have 31 days to enroll your family or change insurance plans. Your deadline date is based on your hire date or the date this letter was mailed, whichever was later. After your deadline, adding family members cannot be done without a qualifying event and changing plans will not be possible until the next open change period.

**Right to Change Benefits - Required Statement:**

Iowa State University reserves the right to amend; modify; revoke or terminate any of the benefit plans, in whole or in part, at any time. The authority to make any such changes to the plans rests with the University Administration and the Iowa Board of Regents.

**Iowa Fair Information Practices Act - Required Statement:**

Iowa State University requests information for the purpose of maintaining the required records for your various University fringe benefit programs. No persons outside the University are routinely provided this information. Responses to items marked (optional) are optional; responses to all other items are required. If you fail to provide the required information, it may result in a delay in providing you with one or more of your fringe benefit programs.

**Social Security Numbers Are Required for Health/Prescription Drug & Dental Coverage:**

If you enroll a spouse/partner and/or dependent children in the health and/or dental plans, we need their Social Security numbers. Social Security numbers provide unique identifiers for your family that aid in processing enrollment information between the vendors and Iowa State University.

In order for Wellmark (the health insurance provider) to report your coverage status to the federal government, you must provide your Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under your coverage and of any member(s) added to your coverage.

If you have a newborn child while you are covered under your group health/prescription drug plan, you must notify us of the newborn’s social security number within six months of the child’s birth.

The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, they will be unable to report and send the information needed to complete federal tax returns.

If you do not provide the Social Security numbers or taxpayer identification numbers for this purpose, you will be subject to a $50 penalty per violation imposed by the Internal Revenue Service.

Federal and State law protects the privacy and security of your SSN and ISU will not disclose your SSN without your consent for any other purposes except as allowed by law. ISU is working to minimize the use of SSN’s within its business processes.

If your family member is a foreign national, without a SSN or tax ID, indicate this on the ISU Plan Benefits enrollment form.
ISU Plan - A Snapshot

Eligibility Requirements:

- Pre/Post-Doctoral Associate employees 1/2 time or more

Health/Prescription Drug & Dental Plans – Pre/Post-Doctoral Associates receive single health /prescription drug insurance coverage as a benefit of employment. Enrollment in the health and dental insurance plan is automatic only for the Pre/Post-Doctoral Associate. Iowa State University also makes additional contributions towards coverage for dependents of Pre/Post-Doctoral Associates.

How the Program Works:

Choose the benefits best suited for your personal situation. Your portion to pay is indicated on the ISU Plan enrollment form. Under the ISU Plan, the University’s contributions toward your benefits (health/prescription drug and dental) will be listed on the payroll information system earnings statement as the ISU Plan Credit. The plan credit is the money ISU provides towards the cost of your benefits. On the earnings statement, the full premium will be indicated. The ISU Plan Credit minus the full premium is the employee amount to pay.

Who is Eligible?

Your eligible dependents to enroll on insurance include:

- Legal spouse (same or opposite sex), if you complete and sign a “Declaration of Domestic Relationship” form.
- Domestic partner (same or opposite sex), if you complete and sign a “Declaration of Domestic Relationship” form. Imputed income may apply.*
- Natural child or legally adopted child and your stepchild or foster child up to age 26 (provided they are not already covered under the plan as an employee or by another employee).
- Coverage can also continue beyond age 26 if a child is incapable of self-support because of a developmental or physical disability and was covered at the time of disability. Contact the insurance company for verification of disability requirements prior to the child’s 26th birthday.
- Unmarried children, age 26 or over, who are full-time students. Imputed income may apply.*

*See Page 7
*Notice Regarding Imputed Income:*

If there is additional benefit provided to the Pre/Post-Doctoral Associate or if adding non-qualified dependent, results in the reduction of taxable gross wages, there would be a requirement to impute income.

- Continuing health/prescription drug or dental coverage for full time students over age 26, who do not meet the definition of a dependent under Federal and State tax laws.
- Insuring domestic partner, who does not meet the definition under the Federal and/or State tax laws.

**Coverage for Adult Children**

**Before age 26:**

- Under the Affordable Care Act (Healthcare Reform), children may be covered under their parent/guardian’s health insurance policies (health, prescription drug, dental and/or vision) up to age 26, regardless of student or marital status.

**After age 26:**

- An eligible child is disabled before age 26 and remains unmarried after age 26.
- An eligible child is unmarried and a full-time student.

**Enrollment:**

- Pre/Post-Doctoral Associates may enroll adult children meeting the conditions above during their initial enrollment.
- If you do not enroll them during the initial enrollment or with a qualifying life event, you will have to wait until the next open change period to enroll them on your available plans.
  - Once you enroll them, you will not be able to drop their coverage until the next open change period unless there is a qualifying event.

The assumption will be made that any dependent enrolled by the Pre/Post-Doctoral Associate meets all conditions to be a valid member. Pre/Post-Doctoral Associates are responsible for reporting eligibility changes for any participant of their insurance policies within 30 days of an event. As long as unmarried adult children are full-time students at an accredited post-secondary institution, there is no age limit or Iowa residence requirement and those children may remain on their parent’s insurance policies, until their status changes.

**Termination of adult children:** coverage will term December 31 of the year the dependent reaches age 26.

**Termination of unmarried, full-time student over age 26:** coverage will term at the end of the next month child marries or ends full time student status
Examples:

- Child is 25 or younger is added to insurance. On March 3rd the child turns 26 and is not a full-time student. If not a full-time student by December, Coverage would have to end on December 31 but could end earlier if there is an event that allows a change.
- Unmarried child is 26 or older on March 3rd and is a full-time student. Child graduates on May 15th and is not a full-time student. Coverage must terminate on June 30.
- Unmarried child is 26 or older and is a full-time student. The child marries in August, coverage ends on September 30.

There will be periodic verification notices for full-time students. The notice may be from Iowa State University or the insurance companies.
Notice of Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA):

While you are a Pre/Post-Doctoral Associate of the State of Iowa, your children are **not eligible** for the Children’s Health Insurance Program (CHIP), known in Iowa as “healthy and well kids-Iowa” or “hawk-i”. There may be a premium assistance program that may assist in paying towards another employer-sponsored health plan. The State uses funds from the Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but qualify for assistance in paying for the health premiums.

If you or your dependents are already enrolled in Medicaid or hawk-i, contact your State Medicaid or hawk-i office to confirm ineligibility and to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or hawk-i, and you think you or any of your dependents might be eligible for either of these programs; you can contact your State Medicaid or CHIP office or dial 877-KIDS NOW (877-543-7669) or [www.insurekidsnow.gov](http://www.insurekidsnow.gov) to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for another employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or hawk-i, another employer’s health plan is required to permit you and your dependents to enroll in the plan as long as you and your dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

To see a list of States who have a premium assistance program since March 3, 2010, or for more information on special enrollment rights, you can contact either:

<table>
<thead>
<tr>
<th>U.S. Department of Labor Employee Benefits Security Administration</th>
<th>U.S. Department of Health and Human Services Centers for Medicare &amp; Medicaid Services</th>
</tr>
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<tbody>
<tr>
<td>866-444-EBSA (3272)</td>
<td>877-267-2323, Ext 61565</td>
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</table>
All international Pre/Post-Doctoral Associates (F and J Visa) are required to carry health insurance for themselves for any semester in which they are registered at Iowa State University. Accompanying dependents must also be enrolled in the health insurance.

Internationals Pre/Post-Doctoral Associates are defined for this purpose as students who are not U.S. citizens, U.S. permanent residents or refugees.

The Pre/Post-Doctoral Associates ISU Plan is mandatory as a condition of your enrollment to the University. You will be automatically enrolled in the ISU Plan for the health - Wellmark PPO (Alliance Select)/Express Scripts (prescription drug) and the dental - Delta Dental - Basic.

Qualifying Life Event:

If spouse/dependents move back to their home country, you would be allowed to drop them from your health/prescription drug and/or dental insurance plans.
You elect to make benefit changes during the open change period or with a qualifying event or become ineligible or ISU makes changes to the plans. Payroll deductions, which cover these benefits, are taken from your pay year round. When deductions are on a pre-tax basis, the Internal Revenue Service regulations are followed for mid-year changes.

*It is your responsibility to contact the benefits office to drop dependents within 30 days of loss of eligibility. Dropping after 30 days may result in ineligibility for refunds of overpayments.*

**Qualified Life Events:**

When enrolled in the health and dental insurance your benefit elections remain in effect until a change is made. You cannot make any plan changes until the next open change period unless you experience a qualified life event and the benefit change you request is consistent with the event. For example, a marriage is a family status change that would allow you to change from single health coverage to different tier of health and or dental coverage because acquiring a spouse is consistent with a gain in eligibility for health or dental coverage.

Qualified events are defined by Section 125 of the Internal Revenue Code, based on individual circumstances and plan eligibility. The following list may not apply to every benefit plan.

**Qualified Life Event Categories:**

You may be able to change your benefit elections if…

You have a change in your **legal marital status**.

You have a change in the **number of your dependents**.

You have a change in your **employment status**.

Your **spouse or dependent** has a change in their **employment status**.

Your **dependent** has a change in his or her **eligibility status**.

You, your spouse or dependent has a **change in residence**.

You, your spouse or your dependent becomes entitled to **Medicare or Medicaid**.

You are served with a **judgment, order or decree**.

There is a **change in cost** by your **dependent care provider**.

This list may not apply to every benefit plan.
Opportunities to change coverage during the year:

Since you are already enrolled in the health plan, HIPAA allows you to add eligible family members to your already existing health/prescription drug and/or dental plan within 30 days of the following events:

- Loss of other health coverage
- Marriage
- Divorce or legal separation
- Death of spouse or dependent
- Adoption or placement for adoption (within 60 days of the event)
- Birth (within 60 days of the event)

Finally, if you are already enrolled in a health/prescription drug plan, the following life event may allow you to enroll in a different health/prescription drug plan regardless of whether you are adding eligible family members.

- Change to out-of-state address

Changing Your Coverage:

When any qualifying event occurs, contact the benefits office to change coverage:

**Drop Who’s Insured**

- Notification within 30 days of loss of eligibility.
- Dropping after 30 days may result in ineligibility for refunds of overpayments.

**Adding Who’s Insured**

- Notify within 30 days of the event (60 days in the case of birth or adoption) for the change to be accepted.
- Otherwise, you will have to wait for the next open enrollment period in which you are eligible to participate and have the change become effective the following February 1.
- You may be asked to provide documentation of the change.

If you have a change in family status, you may make certain changes to some of your benefits. **You must make your change within 30 days of the event**, except you have **60 days** to add a newborn, newly adopted child or a dependent previously covered by Medicaid, Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) or Healthy and Well Kids in Iowa (hawk-i). Please note: **dependents of Pre/Post-Doctoral Associates are not eligible for hawk-i**.

You must **always** complete Enrollment/Change form when adding a newborn; or other eligible dependents.

To discuss event qualifications/changes allowed and to obtain appropriate forms, contact University Human Resources, Service Center at 515-294-4800 or 877-477-7485 and ask to speak to a Benefit Consultant.
EXAMPLES:

- **Health/Prescription Drug Plan** – With the birth of a child or other qualifying events, you may add dependents. A newborn child may be added, but your spouse/domestic partner and other dependent children not previously enrolled may not be added as special enrollees. Without the qualifying event, any dependent must be added during the open change period, see below.

If you are enrolled in the ISU HMO Plan and you or your dependent moves outside the HMO network area, you may change your plan to the ISU PPO Plan. The HMO has the option of Guest Membership when a dependent is out of the State (see Health page 16 for details).

- **Dental Plan** – When adding dependents: a newborn child may be added, but your spouse/domestic partner and other dependent children not previously enrolled may only be added with the 12-month deferral of coverage for Basic and Major Restorative Services. This waiting period may be removed before it would otherwise expire if proof of your good dental health is submitted to and approved by Delta Dental. They will determine the type and form of required proof. You must pay the cost of obtaining that proof.

**Annual Open Change Period:**

*It is the participant’s responsibility to be aware of open change and to review the benefits for changes.*

Iowa State University holds an open change period annually:

- Beginning at 8:00 a.m. the first working day in November
- Ending at 5:00 p.m. the Friday before Thanksgiving
- Notification will be sent to campus e-mail addresses with information regarding open change period
- Information regarding the open change period will be available on the benefits web page at [http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits) in November

Annual reenrollment is not required. Iowa State University may make changes to all benefits. Any changes are communicated during the open change period. The open change guide is available on the ISU Benefits web page or AccessPlus from menu title “Benefits Info”. Otherwise, once elected, coverage continues until the employee makes a change during the annual open change period.

**Effective Dates for changes made during open change period:**

- February 1 – health/prescription drug and dental insurance

**Possible Changes**

- Health Plan - You may change from one health plan to another. During this period you may also add or remove dependents.
- Dental Plan - You may change from one dental plan to the other or begin basic coverage without incurring the deferred coverage waiting period. During this period you may change from the Basic Plan to the Comprehensive Plan or from the Comprehensive Plan to the Basic Plan (see information in Dental section regarding the three-year lock-in on the Comprehensive Plan). During this period you may also add or remove dependents.
Iowa State University offers Pre/Post-Doctoral Associate participants a choice of two group health insurance plans - the ISU PPO Plan (Alliance Select), and the ISU HMO Plan (Blue Advantage). You will be automatically enrolled in the PPO plan. You must complete a form to elect the HMO plan option.

You may also select a tier of coverage when adding spouse and/or dependents: Yourself and Your Spouse or Domestic Partner, Yourself and Your Child(ren), or Yourself and Your Family.

**Date Coverage Begins:**

Coverage is effective on the first day of active work (yourself only tier of coverage). You will have until your assigned deadline, which is found on your Welcome Letter, to change coverage or add spouse and/or dependents.

If you are not actively at work on the date coverage would otherwise be effective, your coverage will not be in force until the day you begin active employment.

**Pre-Existing Conditions:**

The Iowa State University health insurance policies have no waiting periods or exclusions for pre-existing conditions for new employees. Employees and their eligible dependents have full coverage as of the effective date, if enrolled by the assigned deadline.

**Cost of the Plans:**

The employee monthly premium for yourself only, ISU Plan PPO is $20.00 per month. Premiums for the plans/tiers of coverage are indicated on the enrollment form. These premiums are usually paid one month in advance.

Under the ISU Plan, the University’s contributions toward your benefits (health and dental) will be listed on the payroll information system earnings statement as the ISU Plan Credit. The plan credit is the money ISU provides towards the cost of your benefits. On the earning statement, the full premium will be indicated. The ISU Plan Credit minus the full premium is the employee amount to pay.

**Automatic Enrollment:**

As a Pre/Post-Doctoral Associate you are automatically enrolled in the following insurance plan:

- Wellmark BC/BS Alliance Select - ISU Plan PPO
- Yourself only coverage

**Family Members:**

If you wish to add a spouse/domestic partner and/or children to your plan you must complete an enrollment form.
Double Spouse Option:

The double spouse/domestic partner option is a contract when both spouse/domestic partner work at Iowa State University and covered by the ISU Plan insurance and are insuring a family. Review options with assistance from the ISU Benefits office.

Deadline:

You will have until your assigned deadline to change your dental plan and to add family members.

On the enrollment form, in the section titled “You and Your Dependents”, please indicate the Name, Social Security Number and Gender for yourself and each of your dependents. This is very important information and should be completed accurately and in full. See statement on SSN requirement on page 5.

If you enroll in the ISU HMO Plan, you must designate a Primary Care Physician (PCP) for each covered person. The network PCP names and numeric codes are listed in the online Provider Directory, which you can find at the Wellmark website: www.wellmark.com. You may change your PCP effective the first of the month following notice by contacting Wellmark customer service directly. Contact Wellmark if you have questions regarding the PCP choice.

You will have until your assigned deadline to change your health plan and to add family members.

ISU Health Plans:

Wellmark Blue Cross/Blue Shield of Iowa is the plan administrator.

The benefit provisions for both ISU Health plans are compared in the summary chart on pages 18 through 19. Please review these comparisons, the summary of benefits and coverage or the certificates available on-line carefully before making your decision.

The ISU PPO Plan (Alliance Select) is a managed care plan that gives you a choice each time you need health care to access a Blue Cross/Blue Shield Preferred Provider.

The ISU HMO Plan (Blue Advantage) is a managed care plan that requires you to receive all of your health care through a Wellmark Health Plan of Iowa (WHPI) network based physicians. A Primary Care Physician, whom you choose from the network directory, coordinates your health care by referral to network specialists. You pay the full cost of any care you receive outside the network, except for emergency care when you are traveling out of the service area.

Identification Cards:

- PPO – cards will be issued in the contract holder’s name and mailed to your U.S. home address. Enrolled family participants have identical cards.
- HMO – cards will be issued, one in each participant’s name on the contract holder’s policy and mailed to your U.S. home address. In addition, each card will indicate that participant’s Primary Care Physician (PCP) but not the OB/GYN PCP, if designated for female participants.
Wellmark PPO (Alliance Select) *

- This plan design has a network of participating physicians throughout the U.S.A.
- Allowed to have the flexibility of service from participating providers that are contracted with Blue Cross and Blue Shield, Alliance Select.
- In-Network – no deductible, $20 office co-payment (which does not apply to out-of-pocket maximum) and/or 10% co-insurance. Includes routine annual physical exams and any related lab exams, hearing and eye exams.
- Out-of-Network refers to physicians that are not contracted with Blue Cross and Blue Shield as preferred providers. Out-of-Network – $300 single/$600 spouse/partner/child/family contract deductible, 20% co-insurance. No coverage for routine services (annual physical and any related lab tests, hearing and eye exams).
- Self-referral allowed – if you feel an injury or illness warrants specialty care you are allowed to make an appointment with the specialist without going through a primary care physician. The specialist may require the referral, but your plan design does not.
- $100 emergency room co-payment which is waived if admitted.
- Out-of-pocket maximum of $1,500 per single contract and $3,000 per spouse/partner, child or family contract on eligible health expenses.

Wellmark HMO (Blue Advantage) *

- This plan design has a network of participating physicians based in Iowa. Current participation is 99% of hospitals (acute care), 93% of primary care physicians (includes pediatricians), 91% of OB/GYN physicians, and 93% for specialists that are participating in the network.
- Each member in the contract is required to designate a primary care physician (PCP). Female participants may elect to also designate a primary OB-GYN physician for their yearly exams.
- For service directed by your elected PCP there is: $10 co-pay for office calls – preventative, outpatient mental health/chemical dependency.
- $10.00 co-pay for in-network chiropractic care and acupuncture services.
- For service directed by your elected PCP there is $0 deductible and $0 co-insurance.
- There is a $100 emergency room co-payment which is waived if admitted.
- If you require care from a specialist, you may see a provider in the Network with referral from PCP. If you require services that are not available from a specialist within the Network, you will be referred to a provider outside the Network who has expertise in diagnosing and treating your condition. Wellmark must approve out-of-Network referrals before you receive services or the services will not be covered. Please note: Even when your out-of-Network referral is approved, you are still responsible for complying with notification requirements. See Notification Requirements and Care Coordination in the Wellmark certificate accessible from the ISU Benefits web page.
- Referrals are not required for chiropractor visits, hearing exams, vision exams or acupuncture.
- Unless an emergency and care is received in an emergency room or admitted from an emergency room or a prior authorization by Wellmark has been completed, there is no coverage outside of the Blue Advantage network.
- Guest membership: this is an added benefit while away from home for 90 or more consecutive days. The guest membership includes access to Blue Cross and Blue Shield participating hospitals, physicians and other health care providers from which you can receive covered services. It is important to note: preventative services are not covered unless performed by the member’s designated Wellmark Health Plan of Iowa primary care physician. This guest membership is a valuable service for: long-term out-of-state travelers (traveling up to 180 days), dependent children who attend college full-time out of state, and family members who reside in another state but are covered under the same health plan. To request this service contact Wellmark Customer Service, the telephone number can be found on the back of your health insurance card.

* This is a summary. Benefits will be administered as described in each plan’s subscriber agreement or plan document.
Each health insurance carrier has determined that the following shaded counties have adequate participating providers to offer services as noted. There may be participating providers in a county that is not shaded. Please check the provider directories for any plans that interest you to ensure that there are participating doctors, specialists, labs, hospitals, clinics, etc. in your area.

**VERY IMPORTANT:** Services will not be paid by the carrier if you do not follow the WHPI network requirements regarding providers for all your health care needs.

*All of the shaded Counties are covered by the WHPI network.*
This is a limited comparison of benefits. The Summary of Benefit and Coverage for each plan is available on-line, see page 74 for details. Benefits will be administered as described in each plan’s subscriber agreement or plan document. For further detail, refer to those documents or call Wellmark Blue Cross/Blue Shield. If there are discrepancies between this comparison and Wellmark’s benefit certificates, the certificates will govern in all cases.

<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>PPO (Alliance Select)</th>
<th>PPO (In Network)</th>
<th>PPO (Out-of-Network)</th>
<th>HMO (Blue Advantage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits from non-participating providers.</td>
<td>Refer to out of network column</td>
<td>80% coverage to MAF (maximum allowable fee) after deductible. You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the health out-of-pocket limit.</td>
<td>None, unless prescribed and referred by participating physician and Wellmark or in an emergency health situation.</td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$400 - single</td>
<td>$1,000 - spouse/child/family</td>
<td>$0</td>
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<td>Out-of-pocket Limit</td>
<td>$1,500/single contract $3,000 spouse/child/family contract/year and Separate prescription out-of-pocket limit of $1,500/single/$3,000 spouse/child/family</td>
<td>$3,000 - single contract/year $6,000 spouse/child/family contract/year and Separate prescription out-of-pocket limit of $1,500/single/$3,000 spouse/child/family</td>
<td>None on health</td>
<td></td>
</tr>
<tr>
<td>Copays DO NOT Apply</td>
<td>None</td>
<td>20% of Maximum Allowable Fee, after deductible</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Coinurance (member pays)</td>
<td>10% of Maximum Allowable Fee</td>
<td>20% of Maximum Allowable Fee, after deductible</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Large case management</td>
<td>Alternative care set up on a case-by-case basis by insurance company</td>
<td>Alternative care set up on a case-by-case basis by insurance company</td>
<td>Directed by PCP</td>
<td></td>
</tr>
</tbody>
</table>

Lifetime maximum benefit – none

**PROFESSIONAL OFFICE SERVICES**

- **Acupuncture**: Not covered. $10/visit copay then $500 annual maximum benefit/member, self-referral to provider for up to 5 visits/condition.
- **Office exam**: $20 copay. $0. $10 copay.
- **Allergy treatment**: 90% coverage, prior approval for some treatment. 80% coverage after deductible, prior approval for some treatment. 100% coverage - directed by PCP.
- **Chiropractic care**: $20/visit co-pay, then 90% coverage. 80% coverage after deductible. $10/visit copay, then 100% coverage, self-referral to network provider.
- **Routine eye exam**: 100% coverage, after $20 copay, including refraction, one per calendar year. Not covered. 100% coverage after $10 copay, one per calendar year, may self-refer to a network provider.
- **Routine hearing exam**: 100% coverage, after $20 copay, one per calendar year. Not covered. 100% coverage after $10 copay, one per calendar year, self-refer to network provider.
- **Maternity**: 90% coverage. 80% coverage after deductible. 100% coverage - directed by PCP.
- **Contraceptive other than prescription**: 90% coverage - outpatient $20 copay - office. 80% coverage after deductible. 100% coverage - outpatient directed by PCP $10 copay - office.
- **Routine physicals**: 100% coverage after $20 copay. Not covered. 100% coverage after $10 copay - PCP.
- **Well child care exams**: 100% coverage after $20 copay. 80% coverage to MAF (maximum allowable fee). 100% coverage after $10 copay - PCP.
<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>PPO (Alliance Select)</th>
<th>HMO (Blue Advantage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Office) Surgery, Radiology &amp; Pathology</td>
<td>90% coverage</td>
<td>80% coverage after deductible</td>
</tr>
</tbody>
</table>

**HOSPITAL SERVICES**

**INPATIENT HOSPITAL SERVICES**

<table>
<thead>
<tr>
<th>Preapproval of inpatient admissions</th>
<th>Required</th>
<th>Required</th>
<th>Directed by PCP - preauthorization required</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-patient Hospital Services Room &amp; Board Inpatient-Physician Services Inpatient - Supplies Inpatient Surgery</td>
<td>90% coverage; prior approval required for certain procedures</td>
<td>80% coverage after deductible; preadmission approval and prior approval required for certain procedures</td>
<td>100% coverage - PCP or referred by PCP</td>
</tr>
</tbody>
</table>

**OUTPATIENT HOSPITAL SERVICES**

<table>
<thead>
<tr>
<th>Ambulatory Surgical Center – Outpatient Surgery</th>
<th>90% coverage; prior approval required for certain procedures</th>
<th>80% coverage after deductible; preadmission approval and prior approval required for certain procedures</th>
<th>100% coverage - PCP or referred by PCP and prior approval required for certain procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Diagnostic Lab, Radiology</td>
<td>90% coverage; prior approval required for certain procedures</td>
<td>80% coverage after deductible; preadmission approval and prior approval required for certain procedures</td>
<td>100% coverage - PCP or referred by PCP</td>
</tr>
</tbody>
</table>

**EMERGENCY CARE**

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>90% coverage</th>
<th>80% coverage after deductible</th>
<th>100% coverage - medically necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Center</td>
<td>90% coverage</td>
<td>80% coverage after deductible</td>
<td>100% coverage - medically necessary</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>$100 copay then 90% coverage; co-insurance follows copay; copay does not apply to out-of-pocket limit; copay waived if admitted</td>
<td>$100 copay then 80% coverage; copay does not apply to the plan out-of-pocket limit; copay waived if admitted but then deductible applies</td>
<td>$100 copay then 100% coverage-waived if admitted</td>
</tr>
</tbody>
</table>

**BEHAVIORAL HEALTH SERVICES**

<table>
<thead>
<tr>
<th>Inpatient mental health and chemical dependency treatment</th>
<th>90% coverage</th>
<th>80% coverage after deductible; preadmission approval required</th>
<th>100% coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health and chemical dependency treatment</td>
<td>100% coverage</td>
<td>100% coverage</td>
<td>100% coverage</td>
</tr>
</tbody>
</table>

**OUTPATIENT THERAPY SERVICES**

| Speech, occupational and respiratory therapy | 90% coverage, prior approval for some treatment | 80% coverage after deductible, prior approval for some treatment. | 100% coverage - directed by PCP |

**THIS COMPARISON IS ONLY A LIMITED SUMMARY OF BENEFITS. BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT OR PLAN DOCUMENT.**
The prescription plan is administered by pharmacy benefit manager, Express Scripts.

The ISU Plan offers a pharmacy program that is administered separately from your health plan. There is not a separate premium to pay for prescription coverage. The cost of the health and prescription plans is combined into the health premium.

The percent of co-insurance is determined by Express Scripts at the point of sale: either at a participating retail pharmacy or Express Scripts by Mail.

- **Identification Cards**: you will have a separate prescription benefit card from Express Scripts. Cards will be issued in the contract holder’s name and mailed to your U.S. home address. Enrolled family participants have identical cards.

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>$0</th>
</tr>
</thead>
</table>
| Out-of-Pocket Maximum | $1,500 / single contract / year  
 | $3,000 / spouse/partner/child/family contract / year  
 | Separate from applicable health plan out-of-pocket |
| 30-day supply – Retail Pharmacy |  
 | For prescription medications used on a short-term basis  
 | Limited coverage for non-participating pharmacies. |  
 | $10 copay for generic  
 | 30% coinsurance for preferred brand name ($100 maximum copay/prescription)  
 | 50% coinsurance for non-preferred brand name ($200 maximum copay/prescription) |
| 90-day Supply – Retail Pharmacy |  
 | For prescription medications used on a regular basis (for 3 months or more)  
 | Limited coverage for non-participating pharmacies. |  
 | $30 copay for generic  
 | 30% coinsurance for preferred brand name ($300 maximum copay/prescription)  
 | 50% coinsurance for non-preferred brand name ($600 maximum copay/prescription) |
| 90-day Supply – Express Scripts Home Delivery Pharmacy |  
 | For prescription medications used on a regular basis (for 3 months or more) |  
 | $0 copay for generics  
 | 25% coinsurance for preferred brand name ($250 maximum copay/prescription)  
 | 33% coinsurance for non-preferred brand name ($500 maximum copay/prescription) |

Be aware the prescription coverage has clinical programs which add step therapy and/or prior authorization requirements. These programs enhance health and safety through greater medication compliance and adherence to prescribed therapies. This helps patients avoid negative outcomes as a result of incorrect dosing, drug interactions, or treatments prescribed for non-approved indications or treatment guidelines. The programs target conditions that are considered chronic and complex, many of which are treated with specialty medications.
Do you have any maintenance medications? Use Express Scripts Home Delivery Pharmacy!

Enjoy convenient mail order for your prescriptions. You will find this service safe, secure and with a cost savings!

If you take prescription medication on an ongoing basis, your prescription drug plan may allow you, for chronic conditions, to order prescriptions from Express Scripts home delivery pharmacy. Once you start, you can refill and renew your prescriptions right at the Express Scripts site and benefit from free standard shipping.

Take advantage of prescription home delivery service, which offers you the ultimate in ease and convenience when purchasing prescriptions.

- Ask your doctor if your prescription can be written for a 90-day supply (plan's home delivery limit) with refills when appropriate instead of 30-day supply with refills.
- It is important to ask for a 90-day supply, as opposed to a 30-day supply, in order to receive up to 90 days of medication for one home delivery co-payment. Please note that you will be charged a home delivery co-payment regardless of the number of days' supply written on the prescription, so make sure your doctor has written the prescription for 90 days.

Please note that the actual quantity and/or days' supply may vary for each drug. Your doctor's instructions on how to take the medication, state and federal dispensing guidelines, or how the medication is packaged may impact the quantity and/or days' supply you can receive.

Getting Started:

From the homepage of Express Scripts you can set up a profile to monitor retail prescription purchases and reorder mail order prescriptions. The web address is: [https://www.express-scripts.com/](https://www.express-scripts.com/).
Iowa State University offers to Pre/Post-Doctoral Associate participant’s a choice of two dental insurance plan options. The default plan option is Basic Plan. You must complete a form to elect the Comprehensive Plan. Delta Dental is the plan administrator.

You may also select a tier of coverage when adding spouse and/or dependents: Yourself and Your Spouse or Domestic Partner, Yourself and Your Child(ren), or Yourself and Your Family.

**Date Coverage Begins:**
Coverage is effective on the first day of active work (yourself only tier of coverage). You will have until your assigned deadline, which is found on your Welcome Letter, to change coverage or add spouse and/or dependents.

If you are not actively at work on the date coverage would otherwise be effective, your coverage will not be in force until the day you begin active employment.

**Pre-Existing Conditions:**
The Iowa State University dental insurance policies have no waiting periods or exclusions for pre-existing conditions for new employees. Employees and their eligible dependents have full coverage as of the effective date, if enrolled by your assigned deadline.

If you are not actively at work on the date coverage would otherwise be effective, your coverage will not be in force until the day you begin active employment.

**Cost of the Plans:**
The employee monthly premium for yourself only, ISU Plan Basic is $0.00 per month. Premiums for the other tiers of coverage are indicated on the enrollment form.

Your portion to pay is indicated on the ISU Plan enrollment form. Under the ISU Plan, the University’s contributions toward your benefits (health/pharmacy and dental) will be listed on the payroll information system earnings statement as the ISU Plan Credit. The plan credit is the money ISU provides towards the cost of your benefits. On the earning statement, the full premium will be indicated. The ISU Plan Credit minus the full premium is the employee amount to pay.
Automatic Enrollment:

As a Pre/Post-Doctoral Associate you are automatically enrolled in the following insurance plan:

- Delta Dental of Iowa – ISU Plan Basic
- Yourself only coverage

Family Members:

If you wish to add a spouse/domestic partner and/or children to your plan you must complete an enrollment form.

Double Spouse Option

The double spouse/domestic partner option is a contract when both spouse/domestic partner work at Iowa State University and covered by the ISU Plan insurance and are insuring a family. Review options with assistance from the ISU Benefits office.

Deadline:

You will have until your assigned deadline to change your dental plan and to add family members.

You may add coverage for dependents mid-year if there is a “family status change” (defined by IRS).

Identification Cards:

- Cards will be issued in the contract holder’s name and mailed to your U.S. home address. Enrolled family participants have identical cards.

Dental Plan Options:

**NOTE:** The Comprehensive Plan has a three-year lock-in provision. If you choose this option, coverage will remain in effect until you elect to change during an open change period following three full years of participation. The change would be effective the following February 1.

The services of any licensed dentist will be considered. However, if your dentist is not participating with Delta Dental you will be responsible for co-insurance and any amount billed over the Maximum Plan Allowance (Delta Allowance) limit established by Delta Dental.

Limitations may apply. Once maximum benefit is used in a benefit year any additional services will be patient liability. Benefits will be administered as described in the plan certificate, which can be found on the Benefit web page, see navigation on page 47.
The benefit provisions for the Basic Dental Plan and the Comprehensive Dental Plan are compared in the chart below. Please review these comparisons carefully before making your decision.

<table>
<thead>
<tr>
<th>Plan Provisions</th>
<th>Basic Option</th>
<th>Comprehensive Option (requires 3-year lock-in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>None</td>
<td>$25 annual deductible/contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>combined for basic &amp; major restorative</td>
</tr>
<tr>
<td>Annual maximum benefit</td>
<td>$750/person/year – restorative services</td>
<td>$1500/person/year excludes orthodontics</td>
</tr>
<tr>
<td>CheckUp Plus – two routine cleanings &amp; exams, routine bitewing x-ray (in-network).</td>
<td>100% covered and does not reduce maximum benefit of $750</td>
<td>Not applicable in this option, these services are covered but are deducted from the annual maximum benefit</td>
</tr>
<tr>
<td><strong>With BASIC OPTION ONLY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostics/preventative—limitations apply, see certificate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Check-ups</td>
<td>100%--2/year</td>
<td>100%--2/year</td>
</tr>
<tr>
<td>- Cleanings</td>
<td>100%--2/year</td>
<td>100%--2/year</td>
</tr>
<tr>
<td>- X-rays</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>- Topical fluoride—under age 19</td>
<td>1 every 12 months</td>
<td>1 every 12 months</td>
</tr>
<tr>
<td>- Topical fluoride—adults</td>
<td>1 every 12 months</td>
<td>1 every 12 months</td>
</tr>
<tr>
<td>- Sealants—under age 15</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>- Space maintainers—under age 14</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic restorative—limitations apply, see certificate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Non-gold fillings</td>
<td>50%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>- Root canal</td>
<td>50%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>- Treatment for gum disease</td>
<td>50%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>- Extractions</td>
<td>50%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td>- Anesthesia</td>
<td>50%</td>
<td>80%, after deductible</td>
</tr>
<tr>
<td><strong>Major restorative—limitations apply, see certificate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gold and porcelain inlays and onlays</td>
<td>50%</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>- Crowns and jackets</td>
<td>50%</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>- Bridgework</td>
<td>Not covered</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>- Implants</td>
<td>Not covered</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td>- Dentures</td>
<td>Not covered</td>
<td>50%, after deductible</td>
</tr>
<tr>
<td><strong>Orthodontics – no age limit</strong></td>
<td>Not covered</td>
<td>50% coverage, lifetime maximum benefit of $2000 after $50 deductible</td>
</tr>
</tbody>
</table>

**EXAMPLE – Basic Plan only – CheckUp Plus**

<table>
<thead>
<tr>
<th>In-Network Delta Dental Pays</th>
<th>Member Pays</th>
<th>Annual Maximum Remaining after 2 checkups</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>$0.00</td>
<td>$750</td>
</tr>
</tbody>
</table>

From the Member link on the Delta Dental website:

http://www.deltadentalia.com/

- Elect to have explanation of benefits delivered electronically instead of through the mail.
- To view Delta Dental of Iowa’s vision discount program, see page 47.
Life can present unexpected issues like work related stresses, the illness of a family member or a change in finances that can require an objective perspective from professional counselors. Iowa State University recognizes the importance of providing a confidential resource to help you deal with the challenges life sends your way.

The Employee Assistance Program (EAP) is administered by Employee & Family Resources (EFR). It is a benefit designed for you and your eligible family members. ISU provides this benefit at no cost to you or your family members. If you are referred for additional assistance beyond what is provided by your EAP, the financial responsibility will be yours.

Guided by professional counselors, EAP helps you address the challenges that can impact your job performance, stifle your well-being or take a toll on your health. It’s there for you – 24 hours a day – 7 days a week.

What kind of issues does my EAP address?

You can call EAP counselors for any life issue that causes you concern or when you are ready to grow personally and professionally. Some common issues that EAP counselors are ready to help you with include:

- Work stress
- Family and personal relationships
- Emotional or mental health
- Work and life balance
- Substance abuse
- Financial or legal concerns
- Personal growth and development

What services does my EAP provide?

Services through EAP should be used when you are facing a personal problem. The EAP counselors will provide you timely and free access to short-term, confidential, and professional services.

Number of visits allowed at no cost:

- Up to three sessions per year
  - Per separate issue
- Telephone counseling 24/7
  - Unlimited number of calls
How can I find out more about all the services available?

EFR Workplace Services
Employee and Family Resources
505 Fifth Avenue, Suite 600
Des Moines, IA  50309

By phone call:
   Des Moines, IA - 515-244-6090
   Nationwide - 800-327-4692
   TTY - 877-542-6488

By web:  www.efr.org/wps/eap
Enrollment into Retirement Plan:

Domestic Pre/Post-Doctorate Associates who earn $1,000 in two consecutive quarters of employment are automatically enrolled in Iowa Public Employee’s Retirement System (IPERS). International Pre/Post-Doctoral Associates are not eligible, see IPERS website for eligibility requirements.

If you have questions regarding your eligibility or why you are required to participate, please contact the Iowa State University, Payroll Office:

- Phone: 515-294-6556
- Email: payroll@iastate.edu

Once you are eligible and participating in the IPERS program, you will receive a letter from UHR Benefits Office/Payroll instructing you to go to IPERS website to complete the beneficiary form and mail to IPERS for processing.

Additional information on the IPERS program can be found:

- IPERS - www.ipers.org
- Phone: 800-622-3849
- Address: P. O. Box 90117
  Des Moines, IA 50306-9117
All Pre/Post-Doctoral Associates are eligible to participate in a 403(b) group supplemental retirement plan. The group supplemental retirement plan allows enrolled participants to save for retirement by deferring a portion of salary into investments of the participants’ choosing.

Participation in a Tax Sheltered Annuity, (Group SRA or “403(b) Tax Shelters” or Roth 403(b)) at Iowa State University is optional. These are considered elective deferrals and are not matched by any amounts from the University. Supplemental retirement plans provide an additional means to save for your retirement.

Vendors Allowed For Optional Investments:

- TIAA-CREF
- VALIC
- Ameriprise Financial
- MetLife

Contract information is located on the Benefits web page: http://www.hrs.iastate.edu/hrs/benefits.

Effective Date:

If election is made prior to the 15th of the month, it will be effective the month of election or you may elect a future date. The Elective Payroll Reduction Agreement Form is located on the Benefits web page.

Contributions:

Under Section 403(b) of the Federal Internal Revenue Code, employees of an eligible employer may elect to make monthly (or semi-monthly) contributions through a payroll deduction process to a tax-sheltered annuity.

Taxation:

Contributions can be either:

- Pre-tax (standard) - taxation on these accounts occurs whenever the money is withdrawn.
- Post-tax (Roth)

Beginning a Roth 403(b):

Enrollment in the Roth 403(b) feature requires you to be enrolled in a Group Supplemental Retirement Account (GRA or GSRA) with one of the approved vendors listed above.
Comparison of Traditional GSRA and the Roth 403(b):

<table>
<thead>
<tr>
<th></th>
<th>Traditional GSRA ISU 403(b)</th>
<th>Roth 403(b) feature to ISU 403(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax Status of Contributions</strong></td>
<td>Pretax contributions reduce current taxable income.</td>
<td>After-tax contributions do not affect current taxable income.</td>
</tr>
<tr>
<td><strong>Tax Status of Distributions</strong></td>
<td><strong>After Age 59 ½</strong> Taxed as current income.</td>
<td>Tax free and penalty free for investors who have had the account for at least five years.</td>
</tr>
<tr>
<td><strong>Rollovers to Roth IRAs</strong></td>
<td>Not permitted.</td>
<td>May be rolled over directly to a Roth IRA with no tax payment.</td>
</tr>
</tbody>
</table>
There may be other additional discounts in the community that are not included in the following information. Below is a listing of the known value added services with our current vendors:

Additional Benefits with Dental Enrollment:

From the subscriber line on the Delta Dental website:  http://www.deltadentalia.com/subscriber

✓ Elect to have explanation of benefits delivered electronically instead of through the mail.
✓ All Delta Dental subscribers have access to a vision discount program through EyeMed Vision Care.
  o For more information on vision discount services go to above link and click on “Vision Discount”

Additional Benefits with Health Enrollment:

✓ Elect to have explanation of benefits delivered electronically instead of through the mail. Sign up for this great benefit through Wellmark at:  http://www.wellmark.com/Member/UsingBenefits/EOBs.aspx.
✓ Member Discounts and Services:

  As a member of the Blues, you have access to discounts and services through Blue365, a program designed by the Blue Cross Blue Shield Association.

  • Diet
  • Family Care
  • Financial
  • Fitness
  • Hearing
  • Travel
  • Vision

Available discounts and contact information are found on the Wellmark website:  http://www.wellmark.com/Member/UsingBenefits/Blue365.aspx
Additional Discount Program for State Employees:

- This is an employee discount program that allows you to save money by offering substantial savings on popular goods and services.

To register for Perks:

1. Go to: [https://member.perksconnect.com](https://member.perksconnect.com)
2. Click “Register Now” in the upper middle area of the site.
4. Complete the Profile information.

Get discounts at over 300,000 local merchants, 350 national retailers and 200 gift card brands, plus thousands of daily deals and cash back online savings mail.
State Workers Compensation:

This benefit provides coverage for accidents while the employee is on official duty. Coverage under the Iowa Workers’ Compensation Act includes hospital care, surgical services, braces, appliances, etc. It also pays compensation for loss of work time after a three day waiting period, complete disability compensation and compensation for dependents in the case of the death of an employee.

Vacation:

A full-time Pre/Post-Doctoral Associate vacation is accumulated at the rate of two days per calendar month worked. A part-time Pre/Post-Doctoral Associate accumulate amounts equivalent to their fractional appointments. Vacation may accumulate to twice the annual entitlement.

Vacation days are not allowed to carry over from one appointment to another nor can they be paid out at the end of the appointment. In some situations, vacation can carry forward to a Professional & Scientific appointment, if approved by the hiring department.

Pre/Post-Doctoral Associates are not eligible to participate in the ISU Catastrophic Illness or Injury policy. Therefore, you cannot donate or receive donations of leave for a catastrophic illness or injury.

Sick Leave:

Full-time Pre/Post-Doctoral Associate employees accrue sick leave at the rate of one and a half days per calendar month worked with unlimited accumulation. Part-time employees accrue amounts equivalent to their fractional appointments.

Sick leave is not allowed to carry over from one appointment to another nor can sick leave be paid out at the end of the appointment.

Holidays:

The following are University holidays with pay:

- New Years Day
- Martin Luther King’s Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Friday following Thanksgiving Day
- Christmas Day
- One additional holiday per year as officially announced by the administration
- Two personal holidays (added to vacation accrual)
Other Payroll Deductions:

Credit Union: Pre/Post-Doctoral Associates and their families are eligible to join the Greater Iowa Credit Union. The Greater Iowa Credit Union is a member-owned and operated nonprofit corporation that promotes systematic savings and intelligent use of credit through payroll deductions. Further information is available from the Credit Union at 515-232-6310.

The following deductions may be required by Federal and State governments:

- **Federal Social Security and Medicare Tax:**
  *Compulsory* for most employees, deducted from your salary per pay period and subject to maximum deduction as set by Federal law.

- **Federal Income Tax:**
  *Compulsory* for most employees, deducted from your salary per pay period.

- **State of Iowa Income Tax:**
  *Compulsory* for most employees, deducted from your salary per pay period.

- To find Countries eligible for Tax Treaties go to the ISU Payroll website for a listing: [http://www.controller.iastate.edu/payroll/nstreaties.htm](http://www.controller.iastate.edu/payroll/nstreaties.htm).

Payroll and Benefit Information on AccessPlus:

You will be able to see your payroll information on the AccessPlus Web page ([http://accessplus.iastate.edu](http://accessplus.iastate.edu))

- Click on the “Payroll Info” link.
- To obtain your information you will be required to enter either your Social Security or University ID number, along with a password.
  - If you have forgotten your password, take your University ID card to the ISU Card Office, 0530 Beardshear Hall or call Information Technology Services at 515-294-4000 to have it reset for you.

**During the open change period, AccessPlus will allow you to project the effects of various benefit scenarios and how they would change your monthly deductions. Your changes may be submitted electronically during this time.**
Rights and responsibilities under the Family and Medical Leave Act (FMLA):

**Basic leave entitlement:**

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:
- For incapacity due to pregnancy, prenatal medical care or child birth
- To care for the employee’s child after birth, or placement for adoption or foster care
- To care for the employee’s spouse, son or daughter, or parent, who has a serious health condition
- For a serious health condition that makes the employee unable to perform the employee’s job

**Military family leave entitlement:**

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness* ; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee take FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation or therapy for a serious injury or illness.*

“The FMLA definitions of “serious injury or illness” for current servicemembers and veterans are distinct from the FMLA definition of “serious health condition”.

**Benefits and protections:**

During FMLA leave, the employer must maintain the employee’s health coverage under any “group health plan” on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee’s leave.

**Eligibility requirements:**

Employees are eligible if they have worked for a covered employer for at least one year, have 1,250 hours of service in the previous 12 months*, and if at least 50 employees are employed by the employer within 75 miles.

*Special hours of service eligibility requirements apply to airline flight crew employees.
**Definition of serious health condition:**

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee’s job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

**Use of leave:**

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer’s operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

**Substitution of paid leave for unpaid leave:**

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer’s normal paid leave policies.

**Employee responsibilities:**

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer’s normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

**Employer responsibilities:**

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees’ rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee’s leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.
**Unlawful acts by employers:**

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

**Enforcement:**

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.
The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) requires that Iowa State University allow qualified persons (as defined below) to continue group health coverage after it would otherwise end. COBRA applies to group health plans maintained by an employer for health, dental, vision, prescription, health reimbursement and certain Employee Assistance Programs. COBRA does not apply to life insurance or disability benefits.

Please review this Notice carefully and keep with your records. If you are married, please have your Spouse review these materials also. If any individual who is covered under the Plan(s) for which you are being offered continuation coverage does not live with you, you must advise the Iowa State University Benefits Office immediately so a Notice and an Election Form can be forwarded to him or her. COBRA notices will always be sent to the last known address of the covered employee or Qualified Beneficiary.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan. Each Qualified Beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open change and special enrollment rights, if applicable.

I. Qualifying Events/Qualified Beneficiaries.

Those individuals eligible for COBRA continuation coverage as Qualified Beneficiaries are as follows:

A. An employee, Spouse and any Dependent Child(ren) whose coverage ends due to termination of employee’s employment for a reason other than gross misconduct (18 months).

B. An employee, Spouse and any Dependent Child(ren) whose coverage ends due to a reduction in employee’s work hours/layoff (18 months).

C. An employee’s former Spouse and any Dependent Child(ren) whose coverage ends due to divorce or legal separation (36 months). (Also, if an employee eliminates coverage for his/her Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, the later divorce or legal separation would be considered a Qualifying Event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies Iowa State University within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier, in anticipation of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.

D. An employee’s Spouse and/or Dependent Child(ren) whose coverage ends due to the employee’s election to drop out of the plan upon entitlement to Medicare (36 months). If an employee enrolls under Medicare Part A or B before experiencing a Qualifying Event based on terminating employment or a reduction in hours, the maximum coverage for the employee’s Spouse and/or Dependent Child(ren) will be the longer of 36 months beginning with the employee’s enrollment under Medicare and 18 months (29 months with a disability extension) beginning with the date the employee would have had a Qualifying Event based on terminating employment or a reduction in hours/layoff.

E. An employee’s surviving Spouse and/or Dependent Child(ren) whose coverage ends due to the employee’s death (36 months).

F. An employee’s child whose coverage ends because the child ceases to be a Dependent Child under the terms of the Plan (36 months).

G. An Employee’s newborn child or child placed for adoption during a period of continuation coverage. You (or a guardian) have the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable Plan eligibility requirements (18 or 36 months from the date of Qualifying Event).

H. Dependent Child(ren) of the covered Employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered Employee’s period of employment with the Plan Administrator is entitled to the same rights to elect COBRA as an eligible Dependent Child(ren) of the covered Employee upon occurrence of a Qualifying Event.

I. The original 18-month period of coverage available to a Qualified Beneficiary may be extended for an additional 18 months if a secondary event occurs during the initial 18-month continuation period. A secondary event is a termination or reduction of hours/layoff followed by 1) Death of the (former) employee; 2) Medicare enrollment of the (former) employee; 3) Divorce or legal separation of the (former) employee; 4) Dependent Child of the (former) employee ceasing to be a dependent. In secondary events, the 36 months of coverage extends from the date of the original Qualifying Event.
J. If a bankruptcy proceeding under Title 11 of the United States Code results in the loss of coverage of a retired employee covered under the Plan, the retired employee is a Qualified Beneficiary and is entitled for coverage as long as he/she lives. This also applies to the retiree’s Spouse and any Dependent Child(ren). If the retiree dies, the maximum coverage for any surviving Spouse and Dependent Child(ren) is 36 months after the retiree’s death.

II. Notification of Qualifying Events. Under the law, the employer is responsible for knowing when any of the following Qualifying Events occurs: 1) Voluntary termination; 2) Involuntary termination; 3) Reduction of hours/layoff; 4) Death of employee; 5) Medicare enrollment of employee; and 6) Employer’s bankruptcy under Title 11 of the U. S. Code. The employee or a family member has the responsibility to inform Iowa State University Benefits Office of a divorce, legal separation, or a Dependent Child losing dependent status under the Plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. In addition you must notify the insurance carrier if a disabled employee or family member is determined to be no longer disabled. The notice must be given in writing. Notice will be deemed given when delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid), sent by facsimile with confirmation of transmission by the transmitting equipment, or received, or rejected, by the addressee if sent by certified mail, return receipt requested.

To enroll a newborn child onto COBRA during a period of continuation coverage, or to enroll a child placed for adoption, you or a family member must notify the insurance carrier of the birth or placement within the same time limits that pertain to enrollment of like dependents acquired by active employees.

III. Election of Coverage. Each Qualified Beneficiary has the right to independently elect coverage for himself/herself. Any or all Qualified Beneficiaries may elect to continue coverage without regard to the elections made by the other Qualified Beneficiaries. Parents may elect to continue coverage on behalf of their Dependent Child(ren) only. If your employer maintains three separate employer plans (such as health, dental and vision plan) you have the right to pick only those Plan, you want. However, if the employer maintains only one consolidated group health plan (which may include health, dental and vision) you must, in this case, elect or decline to elect COBRA coverage for the consolidated group health plan as a whole.

To continue coverage, complete the enclosed Election Form and return it to the address or fax number indicated on the Form. The Election Form must be completed and returned within 60 days after the Date of Notification reflected on the Election Form or within 60 days after the coverage would otherwise end, whichever is later. If this Election Form is not returned within the 60-day period, the continuation option expires. A Qualified Beneficiary may change a prior rejection of the continuation coverage any time until the end of the applicable 60-day period.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you will lose the right to avoid having pre-existing condition exclusion periods applied to you (this does not apply to dependents under age 19) by other group health plans if you have more than a 63-day gap in health coverage; election of continuation coverage may help you avoid or reduce such a gap in coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusion periods if you do not elect and exhaust the continuation coverage available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed in Section I. You will also have the same special enrollment right at the end of the continuation coverage if you elect and exhaust the continuation coverage available to you.

IV. COBRA Premiums. You must pay the entire premium amount as shown on the enclosed election form for your COBRA coverage. Your COBRA premium is calculated by adding 2% to the applicable premium to cover administrative expenses. If your COBRA coverage is extended to 29 months due to the disability provisions explained in Section VI Item C, COBRA regulations allow premiums to be increased to 150% of the otherwise applicable premium for the 19th through 29th months of COBRA coverage.

If you choose, you may submit your initial payment with the COBRA Election Form. If you do not submit your initial payment with the Election Form, or the payment is insufficient, your first invoiced contribution(s) will be due on or before the 45th day after electing COBRA coverage. If you do not make your first payment for continuation coverage within 45 days, you will lose all continuation coverage rights under the Plan(s).

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan(s) would have otherwise terminated through the end of the current month being billed. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. It is important to note that, if you have chosen the automatic account withdrawal as your payment option, the initial withdrawal from your designated checking or savings account may be more than one month in order to pay your account through Wellmark’s current billing period. If you have questions regarding continuation coverage or payments, please feel free to call the Customer Service number listed on your Wellmark ID card. If you do not have your ID card, please call 1-800-524-9242 to speak with a Customer Service Representative. Payment(s) made at the time of election should be submitted and mailed with the Election Form.
After the initial premium, your monthly premium payment is due on the first day of each month for that month’s COBRA coverage (for automatic account withdrawal, Wellmark allows a premium payment due date of the 1st or the 5th of the month). There is a grace period which expires on the 30th day after the first of the month. If a monthly premium payment is not remitted or cannot be withdrawn from the designated account (for automatic account withdrawal), for any reason, it is your responsibility to ensure that the premium payment is remitted by the end of the grace period for the month for which the premium payment is being paid, in order for coverage to continue. If you do not make the premium payment within the 30 day grace period, COBRA coverage will be cancelled retroactively to the first of the month.

If you have chosen automatic account withdrawal, premium payments will be withdrawn from your designated checking or savings account on the designated day (1st or 5th) of each month. If remitting premium payments after submission of the Election Form, the premium payments should be mailed with your ID number included, to the following address:

Wellmark Blue Cross and Blue Shield
PO Box 1313
Des Moines, IA 50306-1313

Delta Dental – COBRA Administration
P. O. Box 1715
Des Moines, IA 50305-1715

There are specific times within the determination period when a Plan(s) may increase a Qualified Beneficiary’s COBRA premium:

1) The Plan has charged less than the maximum amount allowed.
2) The permitted increase for the disability extension period begins in the 19th month.
3) A Qualified Beneficiary chooses to become covered under a more expensive Plan, when offered, or adds a new benefit, when offered.
4) A Qualified Beneficiary adds a family member, as allowed by the Plan, that would cause the applicable premium to be higher for that family unit size.

V. COBRA Provisions.

A. Any Qualified Beneficiary may elect coverage for an eligible dependent (spouse, newborn child, adopted child, etc.) acquired during a period of continuation. Qualified Beneficiaries must apply to the Wellmark for coverage of acquired eligible dependents within the same limits that pertain to enrollment of like eligible dependents acquired by active employees. Please refer to your Benefit Booklet for provisions regarding dependent eligibility and effective dates. E Elections that are not made on a timely basis will be declined.

B. Your continued coverage(s) will be subject to the same benefit and rate changes, when applicable, as the Plan. You will be notified of any changes in benefits or premium rates.

C. During open change you will have the same options under COBRA coverage as active employees covered under the Plan. In addition, HIPAA’s (Health Insurance Portability and Accountability Act of 1996) special enrollment rights will apply to those who have elected COBRA.

D. If a Qualified Beneficiary moves outside the service area of a region-specified benefit package, the coverage will be changed to the same coverage available to an active employee moving to the same area.

E. A complete description of plan provisions and benefits is outlined in your Benefit Booklet.

VI. Duration of COBRA coverage.

A. If the Qualifying Event is termination of the covered employee’s employment or a reduction in hours/layoff, COBRA coverage continues for up to 18 months from the date on which coverage would otherwise end.

B. If the Qualifying Event is a divorce or legal separation, the death of the covered employee, the covered employee’s enrollment to Medicare, or the loss of Dependent Child status under the terms of the Plan, coverage continues for up to 36 months from the date on which coverage would otherwise terminate.

C. If a Qualified Beneficiary or family member is disabled, an 18-month continuation coverage period may be extended to a maximum of 29 months for all Qualified Beneficiaries enrolled under the covered employee’s contract, if the following conditions are met: 1) the Social Security Administration determines that the Qualified Beneficiary or family member is disabled at any time during or prior to the first 60 days of continuation coverage; and 2) the Qualified Beneficiary provides the insurance carrier with a copy of the determination within the 18-month coverage period and not later than 60 days after a) the date the determination is made by the Social Security Administration, b) the date of the qualifying event, or c) the date on which the Qualified Beneficiary loses coverage under the Plan due to the qualifying event, using the delivery procedures specified in Section II. COBRA regulations allow the premium for COBRA coverage to be increased to 150% of the otherwise applicable premium, after the 18 months of coverage, when COBRA coverage is extended due to disability. The non-disabled family members may also be charged up to 150% of the applicable premium if the disabled individual is part of the coverage.

D. Coverage for a Qualified Beneficiary who is a Spouse or Dependent Child of the covered (former) employee can increase to a maximum of 36 months if any of the following events occur during the initial 18-month continuation period: 1) the covered (former) employee dies; 2) the covered (former) employee and Spouse are divorced or legally separated; 3) (for the Dependent Child only) the Dependent Child loses status as a Dependent Child under the Plan; 4)
the covered (former) employee enrolls in Medicare. Request for such extended continuation must be sent to the insurance carrier within 60 days after occurrence of any qualifying event. The request must be in writing using the delivery procedures specified in Section II.

E. COBRA coverage will terminate (before the end of the maximum coverage periods as described in paragraphs A through D above) on the earliest of the following dates:

1. Retroactive to the first day of the month for which Qualified Beneficiary’s monthly premium is not paid timely;
2. On the date the employer ceases to maintain any Plan for its employees;
3. On the date a Qualified Beneficiary enrolls in Medicare (applies only to the person enrolling in Medicare);
4. Retroactive to the first of the month or on the date a Qualified Beneficiary becomes covered, after electing continuation coverage under another group health plan that does not impose any pre-existing condition exclusion period for a pre-existing condition of the Qualified Beneficiary (note: there are limitations on plans imposing a pre-existing condition exclusion period and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act);
5. For a Qualified Beneficiary entitled to 29 months of COBRA coverage due to his/her disability or the disability of a Qualified Beneficiary or family member under the same qualifying event, coverage will terminate during the 11-month extension if the Social Security Administration later determines that the formerly-disabled Qualified Beneficiary or family member is no longer disabled. The individuals affected must notify the insurance carrier within 30 days of any final determination that the Qualified Beneficiary or family member is no longer disabled. Coverage will terminate the first of the month following 30 days after the date of the final determination that the Qualified Beneficiary or family member is no longer disabled. If a Qualified Beneficiary or family member is deemed no longer disabled, COBRA coverage for all Qualified Beneficiaries who were entitled to the disability extension will also terminate.

VII. Individual Purchase (Conversion). Does not apply to residents outside of Iowa or South Dakota. When continued coverage ends, conversion coverage may be available from insurance carrier for you and/or your Spouse and Dependent Child(ren). An application for conversion coverage and payment of the required premium must be made within 31 days after the COBRA continuation coverage ends. Prescription drug, dental and vision coverage are not available as conversion coverages.

Please note the benefits provided by Wellmark individual plans and the Wellmark conversion policies will not be identical to the coverage provided under the Plan and will be subject to different premium rates. If you wish to receive information about the benefits available under the individual plans or conversion policies and the associated premium rates, contact Wellmark’s Direct Marketing Department at 1-800-722-1795 for additional information.

VIII. For More Information. This Notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan may be available in your summary plan description or from Iowa State University. You may request a copy of your summary plan description from the University Human Resources, Benefits Office, 3810 Beardshear Hall, Ames, Iowa 50011 or by going to the Benefits web page: http://www.hrs.iastate.edu/hrs/benefits.

For more information about your rights under ERISA (Employee Retirement Income Security Act), including COBRA, HIPAA and other laws affecting group health plans, contact the U. S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa or call their toll-free number at 1-888-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

IX. Keep Your Plan Informed of Address Changes. In order to protect your family’s rights, you should keep Iowa State University and the COBRA Administrator (if you have COBRA coverage) informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to Iowa State University or the COBRA Administrator.

X. Questions. If you have any questions regarding continuation coverage or payments, please feel free to call the Customer Service number listed on your Wellmark ID card. If you do not have your ID card, please call 1-800-524-9242 to speak with a Customer Service Representative, or mail your questions to the following address:

Wellmark Blue Cross and Blue Shield
COBRA Administrator, Station 3W395
PO Box 9232
Des Moines, IA 50306-9232

Revised 01/2014
NOTICE OF PRIVACY PRACTICES
FOR
IOWA STATE UNIVERSITY BENEFITS OFFICE
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

800. Purpose of This Privacy Notice
This Notice of Privacy Practices describes how the Iowa State University Benefits Office may use and disclose your protected health information to conduct health care operations, assist with your treatment, initiate payment, and for other purposes that are permitted or required by law. Iowa State University reserves the right to make changes in this Notice of Privacy Practices. The Notice describes your rights to access and control of your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. For purposes of this notice, we will refer to “Protected Health Information” as “PHI”.

800. Who Will Follow This Notice
This notice describes the privacy policy of the Benefits Office at Iowa State University that provides group health plans and other health-related services to you as an employee of ISU. The health plans and other services covered by this notice include:

- Our Self-Insured ISU Plan including the Indemnity, PPO and HMO plans.
- Our Basic and Comprehensive Dental plans.
- Our Health Reimbursement Flexible Spending Account Program.
- Our Vision Insurance Program.

These privacy policies will be followed by:

- All employees of the ISU Benefits Office.
- ISU Departments and their employees that provide support to the ISU Benefits Office and may have access to your PHI while providing that support such as Administrative Data Processing, Accounts Receivable, Internal Audit, University Counsel, and Risk Management.

800. Our Pledge Regarding Your Health Information
We understand that health information about you and your health is personal, and we are committed to protecting it whenever it is in the possession of the ISU Benefits Office.

Your personal health information is required to be kept confidential and private under a number of federal and state laws. For example, Iowa Code Chapter 22.7(2) addresses the confidentiality of public hospital, health and professional counselor records; Iowa Code Chapter 228 addresses the disclosure of mental health and psychological information; the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. §1232(g) and 34 CFR Part 99, addresses the confidentiality of student educational records; and the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320(d) and 45 CFR Parts 160 and 164, addresses the confidentiality of patient health information and records.
We are required by law to:

- Make sure that health information that identifies you is kept private.
- Provide you this notice of our legal duties and privacy practices regarding your health information.
- Follow the terms of the notice that is currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy by contacting the ISU Benefits Office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next visit to the ISU Benefits Office. The current notice and any revised notice are available on the internet on the ISU Benefits Office Website at: http://www.hrs.iastate.edu/benefits/homepage.shtml.

800. How We May Use and Disclose Health Information about You
The following categories describe ways that we use and disclose health information. Examples of each category are included. Not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories:

- **For Health Care Operations:** We may use and disclose your health information to rate our risk and determine our premiums for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to manage our business, and the like.
- **For Payment:** We may use and disclose your health information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine health necessity, to obtain premiums, to issue explanations of benefits to the person who subscribes to the health plan in which you participate, to reimburse you under your health reimbursement flexible spending account and the like.
- **For Treatment:** We may disclose your health information to a doctor or a hospital which asks us for it to assist in your treatment. We may your PHI with third party “business associates” that perform various activities (e.g., billing and collection) for Iowa State University. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

800. General Rule: Uses and Disclosures of PHI Are Based Upon Your Written Authorization
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You may revoke this authorization at any time, in writing, except to the extent that the ISU Benefits Office has taken action in reliance on the use or disclosure indicated in the authorization. Without your written authorization, we may not use or disclose your health information for any reason except those described in this notice.

800. Exception to General Rule for Uses and Disclosures to Family or Friends Involved in Your Health care
Before we disclose your health information to a member of your family, a relative, a close friend or any other person you identify that is involved in your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency treatment situation exists, we will only disclose your PHI to others involved in your health care based on our professional judgment of whether the disclosure would be in your best interest. We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition or death. We will also use our professional judgment and experience with common practice to allow a person involved in your health care to pick up filled prescriptions, health, supplies, x-rays, or other forms of health information. In these situations, only the minimum necessary PHI that is relevant to your health care will be disclosed.
Exceptions to General Rule for Uses and Disclosures of Your PHI That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

7.1 To Iowa State University: We may disclose your PHI and the PHI of others enrolled in your group health plan or health reimbursement flexible spending account program to ISU or other organization that sponsors your group health plan, administers the health reimbursement flexible spending account program, or to permit the plan sponsor to perform plan administration functions. Please see your group health plan document for a full explanation of the limited uses and disclosures that the plan sponsor may make of your health information in providing plan administration. We may also disclose summary information about the enrollees in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the enrollees in your group health plan. The summary information will be stripped of demographic information about the enrollees in the group health plan, but the plan sponsor may still be able to identify you or other enrollees in your group health plan from the summary information.

7.2 For Underwriting: We may receive your health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this health information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. In that case, our use and disclosure of your health information will only be as described in this notice.

7.3 For Marketing: We may use your health information to contact you with information about health-related products and services or about treatment alternatives that may be of interest to you. We may disclose your health information to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt out of receiving further such information by telling us using the contact information listed at the end of this notice.

7.4 Research: Although in most cases health-related research is conducted only after you have provided authorization to disclose your protected health information to the researcher, in certain circumstances when the research proposal has been approved by an institutional review board or is preparatory to research, your PHI may be used or disclosed for health-related research without your authorization.

7.5 Required By Law: We may use or disclose your PHI to the extent that Federal, State or Local law requires the use or disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, when required by law, of any such uses or disclosures.

7.6 Disaster Relief: We may use or disclose your name, location and general condition or death to a public or private organization authorized by law or by its charter to assist in disaster relief efforts.

7.7 Death and Organ Donation: We may disclose the health information of a deceased person to a coroner, health examiner, funeral director, or organ procurement organization for certain purposes.

7.8 Serious Threat to Health or Safety: We may, consistent with applicable law and ethical standards of conduct, use or disclose your PHI if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public. We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

7.9 Specialized Government Functions: We may disclose your PHI when it relates to specialized government functions such as military and veteran’s activities, national security and intelligence activities, protective services for the President, and health suitability or determinations of the Department of State.

7.10 Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.
7.11 Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes may include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) suspicion that death or serious injury has occurred as a result of criminal conduct, (4) in the event that a crime occurs on the premises of ISU, and (5) on the occurrence of a health emergency when it is likely that a crime has occurred.

7.12 Compliance: Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of the HIPAA Privacy Regulations and other Federal or State laws.

8. Your Rights Regarding Your Protected Health Information

Following is a statement of your individual rights with respect to your PHI and a brief description of how you may exercise these rights.

8.1 You have the right to access, inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in our records for as long as we maintain the PHI. We will respond to your written request to inspect and/or copy within 30 days. We may charge you a fee for the cost of copying the documents involved. There are a few limited exceptions to your right of access. Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, you may have a right to have a decision to deny access reviewed. Please contact the ISU Benefits Office if you have questions about access to or decisions concerning your PHI.

8.2 You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to any restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. You will not be bound unless our agreement is so memorialized in writing. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You may make a request that we send you confidential communications by alternative means or to you at an alternative location. This request must be in writing and must contain a statement that disclosure of all or part of the information could endanger you if it is not communicated to you in confidence. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the subscriber of the health plan in which you participate. An explanation of benefits issued to the subscriber for health care that you received for which we did not request confidential communications or about the subscriber or others covered by the health plan in which you participate may contain sufficient information to reveal that you obtained health care for which we paid, even though you requested that we communicate with you about that health care in confidence. Please make this request in writing to the ISU Benefits Office.

8.3 You may have the right to amend your PHI. This means you may request an amendment of PHI about you in our records set for as long as we maintain this information. Your request must be in writing and explain why the information should be amended. We will respond to your written request to amend within 60 days of receiving the request. We may deny your request for an amendment in circumstances where we have not created the information or when we believe that the information is accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact the ISU Benefits Office if you have questions about amending your record.
8.5 You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to others based upon your express authorization, to family members or friends involved in your care, for a facility directory, for notification purposes, or as part of a limited data set that does not directly identify you. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The request for an accounting must be in writing, and we will respond to your written request within 60 days. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

8.6 You will receive a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

9. Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to the ISU Benefits Office using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

THIS NOTICE IS EFFECTIVE ON APRIL 14, 2003.

Iowa State University does not discriminate on the basis of race, color, age, religion, national origin, sexual orientation, gender identity, sex, marital status, disability, or status as a U.S. veteran. Inquiries can be directed to the Director of Equal Opportunity and Compliance, 3210 Beardshear Hall, 515-294-7612.

CONTACT INFORMATION

The Iowa State University Benefits Office

To contact the Benefits Office:
University Human Resources, Service Center
3810 Beardshear Hall

Telephone: 515-294-4800 / 877-477-7485
Fax: 515 294-8226 and E-mail: benefits@iastate.edu
Here are some terms and definitions that are used in various sections of this guide and will help you understand your coverage. Additional definitions can be found in the Certificate of Coverage found in the Health section of the Benefits web page: [http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits).

**COBRA:** The Consolidated Omnibus Budget Reconciliation Act allows you and/or covered dependents to extend health, dental and/or vision coverage beyond the date on which eligibility would normally end. You pay the full premiums plus a 2% administrative fee for this extended coverage.

**Co-insurance:** The cost of a health or dental expense that is shared between you and the plan after you pay any applicable deductible. For example, the ISU PPO plan’s in-network coverage is 90% and your share (co-insurance amount) is 10%.

**Co-payment:** A set dollar amount you pay toward an expense, such as an in-network office visit or prescription drug. The remaining cost is covered by the plan.

**Deductible:** If applicable, the amount of money you must pay toward health, dental or vision expenses for each family member each year before health, dental or vision benefits are reimbursable in most cases. After you have paid the deductible, future expenses are covered at the coinsurance amount. Co-payments do not count toward the deductible on the ISU plans.

**Non-participating Provider:** A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan or Delta Dental.

**Participating Provider:** A facility or practitioner that participates with Blue Cross or Blue Shield Plans, but not with a preferred provider program.

**Preferred Provider:** Providers that participate directly with Alliance Select and providers that participate with other Blue Cross and/or Blue Shield preferred provider organizations (PPO’s).

**In-Network Provider:** Providers that participate directly with Wellmark Health Plan of Iowa (HMO) or Delta Dental.

**Medically Urgent Situation:** A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits plan member seeking services or, is the option of a physician with knowledge of the member’s health condition, would subject the member to severe pain that cannot be managed without the services in question.

**Brand Name Medication:** are drugs that are patented, manufactured and distributed by only one pharmaceutical manufacturer.

**Non-Preferred or Non-Formulary Drugs:** A formulary is a list of preferred medications that a committee of pharmacists and doctors deems to be the safest, most effective and most economical. Non-formulary are not on the list of preferred medications and have the highest copayments, if the medication is covered.

**Generic Medication:** are drugs that are manufactured, distributed and available under a chemical name without patent protection. A generic drug must have the same active ingredients as its brand name counterpart. Generic drugs typically cost less than brand name drugs.
The following is a list of websites and telephone numbers associated with your benefits:

**University Human Resources Service Center**

<table>
<thead>
<tr>
<th>Telephones</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>515-294-4800 / 877-477-7485</td>
<td><a href="http://www.iastate.edu">www.iastate.edu</a></td>
</tr>
</tbody>
</table>

To access the Benefits page, go to the ISU homepage at [www.iastate.edu](http://www.iastate.edu)

- On the index line, click on the letter “B” then look for Benefits Employee and click
- Which will bring you to the Benefits homepage: [http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits)
- On this page, click on your employment classification – Pre/Post-Doctoral Associate classification for each benefit category

**CERTIFICATES OF COVERAGE**

[http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits)

Under each employment classification click on the “Health” or “Dental” line to find the certificates.

**HEALTH PLANS**

Register on-line as member for access to claims information.

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>Telephone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellmark BC/BS of Iowa – Iowa or National site for Nationwide search for providers.</td>
<td>Multisite: 800-494-4478</td>
<td><a href="http://www.wellmark.com">www.wellmark.com</a></td>
</tr>
</tbody>
</table>
  - Click on “Find a Doctor or Hospital” link
  - Click on “Doctors (Iowa, South Dakota & bordering counties)”
  - For information on care outside of Iowa, click on “National Providers”
  - For information on care outside of the U.S., click on “International Providers”
| Blue Advantage (HMO) | 800-494-4478 | [www.wellmark.com](http://www.wellmark.com) |

**PHARMACY BENEFIT MANAGER**

Register as a member for access to retail claims information and begin mail order.

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Telephone</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alliance Select (PPO)</td>
<td>800-494-4478</td>
<td><a href="http://www.wellmark.com">www.wellmark.com</a></td>
</tr>
<tr>
<td>Blue Advantage (HMO)</td>
<td>800-494-4478</td>
<td><a href="http://www.wellmark.com">www.wellmark.com</a></td>
</tr>
</tbody>
</table>

**SUMMARY OF BENEFITS & COVERAGE**

Printed copies are available by request

[http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits) – Under Pre/Post-Doctoral Associate classification click on “Health” line to find the Summary of Benefits & Coverage.

**DENTAL PLAN**

Register as a subscriber to access your dental insurance information and request electronic explanation of benefits.

<table>
<thead>
<tr>
<th>Dental Plan</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delta Dental of Iowa</td>
<td>800-544-0718</td>
</tr>
</tbody>
</table>

[www.deltadentalia.com](http://www.deltadentalia.com)

Call or access Delta website for
- Participating dentist directory – Search under the Delta Dental Premier Plan.
- Access your dental insurance information,
- Request electronic explanation of benefit

Delta Dental also includes a vision discount program through EyeMed click on:
- Member Tab
- Then Vision Discount
| **GROUP SUPPLEMENTAL RETIREMENT PLANS** | TIAA-CREF - [www.tiaa-cref.org](http://www.tiaa-cref.org) or call 800-842-2776 or the Ames Office at 866-904-7803 / 515-268-8600  
VALIC – contact agent at 800-448-2542  
METLIFE – contact Adam Wolff – [awolff@metlife.com](mailto:awolff@metlife.com) or call 800-492-3553  
AMERIPRISE FINANCIAL – contact Richard Keeling – [Richard.j.keeling@ampf.com](mailto:Richard.j.keeling@ampf.com) or call 515-233-5402 |
| **RETIREMENT BENEFIT** | IPERS - [www.ipers.org](http://www.ipers.org) or call 800-622-3849 |
| **EMPLOYEE ASSISTANCE PROGRAM (EAP)** | 800-327-4692  
OR  
Des Moines  
515-844-6090  
EFR Workplace Services  
[www.efr.org/wps/eap](http://www.efr.org/wps/eap) |
| **VENDOR VALUE-ADDED BENEFITS** | WELLMARK – BLUE 365  
DELTA DENTAL – Vision Discount Program  
[http://www.deltadentalia.com/MemberTab/VisionDiscountProgram](http://www.deltadentalia.com/MemberTab/VisionDiscountProgram)  
PERKSPOT  
Use Anytime - discount programs for State employees:  
Go to:  
[https://member.perksconnect.com](https://member.perksconnect.com)  
1. Click “Register Now” in the upper middle area of the site.  
2. In “Your Group Code,” enter STOFIA and click “register.”  
3. Complete the Profile information |