New Employee Benefit Enrollment Guide

2013

Non-Supervisory Merit (Organized) Employees

(Bargaining Unit Classifications Including Confidential Classification)

The benefits in this guide are subject to change each year. Employees are responsible for understanding and reviewing the benefits during the Open Change Period.

Revised for January 1, 2013
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What do I need to do?

☐ Review the entire Enrollment Guide.

☐ Sign-up for a group benefit sessions (see Page 4) and review checklist (see Page 6).

☐ Enroll in your benefits by the assigned deadline which is included in the welcome letter. Failure to enroll in benefits within 31 days will cause you to forfeit your opportunity to elect many benefits.

☐ Keep your benefits current. You are responsible to promptly notify Human Resource Services – Benefits Office of any family status changes (see Pages 11 - 14).
Welcome to the Iowa State University Benefit Program!

The ISU Department of Human Resource Services, Benefits Office welcomes you as a new employee of Iowa State University.

The Human Resources Service Center is located at 3810 Beardshear. The Service Center is where you will sign up for payroll, turn in enrollment forms and check in for an appointment with anyone in the Benefits Office.

The telephone number is (515) 294-4800 / 877-477-7485. 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.

To enroll in the Iowa State University Benefits program, you should attend a group benefit session. The session helps you learn more about the benefit choices.

Please call (515) 294-4800 / 877-477-7485 to schedule your session.

The benefits staff is available to assist you and answer benefit questions. Once you are enrolled, if you need assistance, drop-ins are welcome, but appointments are preferred to ensure a Benefit Consultant is available to meet with you.

Iowa State University provides employees with various kinds of insurance protection and retirement plans. Some programs are optional, and some are automatic or mandated by law. In some cases the University shares the cost of these programs or bears the cost entirely.

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

Enrollment:

Enrollment is optional in all of the plans with the exception of the Long Term Disability Plan and IPERS (Iowa Public Employees Retirement System). Enrollment in optional programs is not automatic. You must enroll within 31 days of your employment at Iowa State University or by the assigned deadline indicated on your letter included with this packet, whichever is later; otherwise certain restrictions may apply.

Most enrollment forms are provided in the back of this booklet. Please bring the forms to the benefit session. You will be given an opportunity at the session to listen to a presentation, request optional enrollment forms and ask questions. The completed forms must be turned in by your assigned deadline, which is on the welcome letter included with your enrollment packet.
Right to Change Benefits - Required Statement:

Department of Administrative Services (DAS) and 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 Dependent Health & Dental Coverage:

If you enroll a spouse/partner and/or dependent children in the health and/or dental plans, we require 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.

Disclosure of your social security number (SSN) is requested from you in order for Iowa State University (ISU) to administer benefits. The Center for Medicare and Medicaid Services (CMS) requires Wellmark (health plan provider) to report SSN for dependents. No statute or other authority requires that you disclose your SSN. Failure to provide your SSN may result in delays in enrollment and claim processing. 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 social security number, indicate this on the Benefits enrollment form.
We ask that you bring the enrollment forms included with this booklet to the benefit session.

Dental Insurance
   ___ Delta Dental Enrollment/Waiver Form

Medical Insurance
   ___ Wellmark BC/BS Enrollment/Waiver Form

Declaration of Domestic Relationship
   ___ Declaration of Domestic Relationship (complete when enrolling same or opposite sex spouse)

Basic/Voluntary Life Insurance  Long Term Disability
   ___ Basic Life Enrollment/Waiver Form  ___ Enrollment Form
   ___ Principal Voluntary Life Enrollment Form  ___ Principal Health Statement Questionnaire
   ___ Principal Beneficiary Designation / Change Form

Eyewear Insurance Plan
   ___ Avesis Enrollment Form

Health Care Flexible Spending Account /Dependent Care Assistance Program / Premium Conversion
   ___ Enrollment/Decline Form

Retirement Fund
   ___ Iowa State University Retirement Plan Election Form and
   ___ TIAA-CREF Application Form or
   ___ IPERS Membership Information and Beneficiary Designation

AVAILABLE BY REQUEST

Medical Insurance
   ___ Wellmark Blue Advantage Enrollment Form available in the Benefits Office or at the session

Declaration of Domestic Relationship Affidavit
   ___ State of Iowa Domestic Relationship Affidavit
      (Completed when enrolling partner of same or opposite sex or common law spouse, request Affidavit)

Retirement Fund
   ___ VALIC contact information (see page 81)
Eligibility Requirements:

- Merit/AFSCME employees
- 1/2 time or more
- Appointed for 9 months or longer
- Budgeted salary of $7,800 or more per year (enrollment into the retirement option)

How the Program Works:

Choose the benefits you want for your personal situation. The amount you pay is indicated in this guide. Your earnings statement, found on AccessPlus on the payroll information system, will indicate the employee amount to pay.

Paying for Your Benefits:

Under the Merit/AFSCME benefits, employees receive an Iowa State University (ISU) contribution towards the cost of the benefits selected. Employees receive the ISU contribution in the following areas:

- **Medical Insurance** – detailed coverage information begins on page 18
  
  Employee choices include coverage for you only or a family. **Family includes**: you and either your spouse/domestic partner and/or eligible children.

  The double spouse/domestic partner option is a shared contract when both spouse/domestic partner work at Iowa State University. If your spouse/domestic partner works for a State of Iowa agency or an ISU Plan (Faculty, Professional & Scientific & Supervisory Merit) employee, review options with assistance from the ISU Benefits office. Also see page 10.

- **Dental Insurance** – detailed coverage information begins on page 15
  
  Employee choices include coverage for you only or a family. **Family includes**: you and either your spouse/domestic partner and/or eligible children.

  The double spouse/domestic partner option may also be available, see “Medical” section above or page 10 for details.

- **Life Insurance/Accidental Death and Dismemberment (AD&D) Insurance** – detailed coverage information begins on page 34
  
  Coverage is for you only. The cost of the Basic Life Insurance is shared by you and the University.
• **Long Term Disability (LTD) Insurance** – detailed coverage information begins on page 31

Coverage is for you only. ISU pays 100% of the premium beginning the first of the next month after one full year of service for the coverage plan of 75% of the first $1,000 and 60% of the remaining balance, which is based on the annual budgeted salary.

**Paid a 9-Month Salary:**

An employee whose annual budgeted salary is paid on a 9-month basis and their appointment is from August to May will usually have three deductions withdrawn from their May pay. These deductions are the premiums for June, July and August for medical and dental coverage and May, June and July’s life and disability coverage.

**Insurance Eligibility for Dependents:**

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. Imputed income may apply.*
- Domestic partner (same or opposite sex), if you complete and sign a “Declaration of Domestic Relationship” form and State of Iowa Relationship Affidavit. 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.*

*Notice Regarding Imputed Income:

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

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

**Coverage for Non-Student Adult Children**

Under the Affordable Care Act (Healthcare Reform), children may be covered under their parent/guardian’s health insurance policies (medical, dental and/or vision) up to age 26 assuming the following conditions:

- An eligible child is married or unmarried and is under 26 years of age.
- An eligible child is disabled before age 26 and remains unmarried after age 26.
- An eligible child is unmarried and while a full-time student after age 26.

Employees may enroll adult children meeting the conditions above during their initial enrollment.

If you do not enroll them during the initial enrollment or a qualifying 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 enrollment and change period unless there is a qualifying event.
Under the law, the coverage for children will terminate at the end of the calendar year of the date the dependent reaches the age 26.

The assumption will be made that any dependent enrolled by the employee meets all conditions to be a valid member. Employees 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.

**Coverage for Full-Time Students**

After age 26 a child must be unmarried and a full-time student. Coverage will terminate the end of the month the child is no longer a full-time student.

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 May 31.

- Unmarried child is 26 or older and is a full-time student. The child marries in August, coverage ends on August 31.

There will be periodic verification notices for full-time students from Department of Administrative Services, Iowa State University or the insurance companies.

**CHIPRA**

**Notice of Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA):**

While you are an employee of the State of Iowa, your children are not eligible for the Children’s Health Insurance Program, known in Iowa as “healthy and well kids-Iowa” or “hawk-i”. However, 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</th>
<th>U.S. Department of Health and Human Services</th>
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<tr>
<td>Employee Benefits Security Administration</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>866-444-EBSA (3272)</td>
<td>877-267-2323, Ext 61565</td>
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**Double Spouse/Domestic Partner Option:**

If both you and your spouse/domestic partner are actively employed by Iowa State University or the State of Iowa in comparable positions that are eligible for benefits, you may enroll in a family plan designating one spouse/domestic partner as the contract holder.

This double spouse option allows sharing the family premium. Your department and your spouse/domestic partner’s department both contribute toward the total premium cost.

It is important you understand the following as it relates to your benefits.

- An employee cannot be enrolled on two contracts as both an employee and a dependent of another employee.
- Child(ren) cannot be covered as dependents by both parents. One spouse/domestic partner must be designated as the “contract holder”. The other will be designated as the “spouse/domestic partner” and is considered a dependent with the children on the contract holder’s policy.
- If both you and your spouse/domestic partner are in the Non-Supervisory Merit category, you will each pay the double spouse share as shown on page 15 for dental and page 20 for medical.
- If your spouse/domestic partner is already employed at a non-Regents State agency, i.e. the Department of Transportation, Natural Resources or other departments, you may elect the double spouse option through your spouse’s/domestic partner’s employer and their insurance options.
  You would be the contributing spouse while they would be the contract holder. The agency should provide copies of the double spouse/domestic partner forms and you must sign up in the Benefits Office in order to participate in this option. Contact the Benefits Office to discuss options.
- Initial enrollment in the double spouse/domestic partner option requires completion of a double spouse/domestic partner form, including the name and social security number of the other spouse/domestic partner. Please contact the Benefits Office if you are electing this coverage for the first time.
MAKING FUTURE CHANGES

The benefit elections you make stay in effect from year to year unless you elect to make a change during the open change period or with a qualifying event. Payroll deductions, which cover these benefits are taken from your pay January through December. When deductions are on a pre-tax basis, the Internal Revenue Service regulations are followed for mid-year changes.

Dental Only Note: 30 days after the initial, eligible event, you will not be able to enroll dependents in the plan until the State of Iowa declares an open change period (this is very infrequent).

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 you enroll in health insurance, dental insurance, vision insurance, life insurance and/or the flexible spending accounts, your benefit elections remain in effect until a change is made. You cannot make any changes until the next enrollment and 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 family health coverage because acquiring a spouse is consistent with a gain in eligibility for health 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.

Opportunities to enroll in coverage during the year
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a special enrollment period for health insurance is available in the following circumstances. You may enroll in the health plan within 30 days of any of the following events:

- Loss of other coverage
- Marriage
- Adoption or placement for adoption (within 60 days of the event)
- Birth (within 60 days of the event)

**Opportunities to change coverage during the year**

If you are already enrolled in a health plan, HIPAA allows you to add eligible family members to your already existing health plan **AND** enroll in a different health 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 plan, the following life events allow you to enroll in a different health plan regardless of whether you are adding eligible family members.

- The commencement of an unpaid leave-of-absence or FMLA leave in excess of 30 days.
- Death of spouse or dependent.
- Return from an unpaid leave-of-absence or FMLA leave in excess of 30 days.

**Changing Your Coverage**

To change your coverage when any qualifying event occurs **you must:**

**Contact the benefits office:**

**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**

- Act 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 enrollment and change period in which you are eligible to participate and have the change become effective the following January 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 State of Iowa employees are not eligible for hawk-i.**

Only the dependents that are affected by the event may be added. For example, a newborn child may be added, but your previously eligible spouse/domestic partner and other dependent children may not be added. 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 Human Resources Service Center at 515-294-4800 or 877-477-7485 and ask to speak to a Benefit Consultant.

**EXAMPLES:**

- **Medical 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 be added as special enrollees. Without the qualifying event, any dependent must be added during the open change period, see below Annual Open Change Period.

If you are enrolled in Blue Advantage or Blue Access and your dependent moves outside the network area, you may sign them up for a Guest Membership (see Medical 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 not be added until the next open change period, which are infrequent. If there is an involuntary loss of coverage, proof of loss of coverage is required.

**Annual Open Change Period:**

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

Iowa State University holds an open change period annually.

- Dates are set by the State of Iowa and will begin prior to October 31
- 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, [www.hrs.iastate.edu/benefits](http://www.hrs.iastate.edu/benefits)

**Annual reenrollment is not required.** The State of Iowa or Iowa State University may make changes to all benefits. Any changes are communicated during the open change period. Otherwise, once elected, coverage continues until the employee makes a change during the annual open change period.

**Effective Dates:**

- January 1 – medical, dental and vision insurance and health care flexible spending account or dependent care assistance program
- January 1 or upon approval – life and disability insurance
- February 1 – vision insurance
• **Medical Plan** - You may change from one medical plan to another without a waiting period for pre-existing condition. During this period you may also add dependents.

• **Dental Plan** - The State of Iowa holds an open change period *periodically*. If there is an open change period you may add coverage or add dependents not currently covered.

• **Basic Life Insurance** - If you initially waive coverage for Basic Life and AD&D coverage by your assigned deadline, you may only apply for the coverage during the open change period. You will be required to complete a Principal Statement of Health Questionnaire to apply for coverage. If approved by the underwriting, coverage will begin on date determined by Principal Financial Group.

• **Health Care Flexible Spending Account and Dependent Care Assistant Program** – Without a qualifying event, the employee contribution will not change unless the employee makes a change during this time. During this time you may begin, stop, increase or decrease participation in either the health care flexible spending account or the dependent care account program.

• **Voluntary Life Insurance** - If you initially waive coverage for Voluntary Life Insurance coverage, you may only apply for the coverage during the open change period, provided you have Basic Life or are applying for Basic Life as well. You will be required to complete a Principal Statement of Health Questionnaire. If approved by the underwriting, coverage will begin on the date determined by Principal Financial Group.

Voluntary Life Insurance coverage may be dropped at any time. You must submit a written request to drop the coverage. The insurance will be dropped by the first payroll available following the day your written request is received by the Benefits Office.

• **Avesis Vision Eyewear Insurance Plan** – You may elect to begin, change or end enrollment in Avesis Vision.
The State of Iowa offers Merit/AFSCME Employees an optional dental insurance plan. Eligible employees may either accept or decline the coverage. Coverage is provided by Delta Dental of Iowa.

**Date Coverage Begins:**

Coverage is effective on the first day of the month following 30 days after the date of employment, providing you enroll prior to your assigned deadline, which is found on your Welcome Letter.

**Pre-Existing Conditions:**

The State of Iowa dental insurance policy has no waiting period 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.

**Enrollment:**

You must complete and turn in the enrollment/waiver form for the dental insurance plan or sign the waiver line. An enrollment/waiver form for Delta Dental is in this packet.

If you sign the waiver line, you will have until your assigned deadline date to change your mind and enroll in the dental insurance plan.

**Note:** After your initial enrollment time, you will not be able to enroll in the plan until the State of Iowa declares an open change period (this is very infrequent).

**Identification Cards:**

Cards will be issued only in your name as the contract holder. Enrolled family participants will have identical cards.

**Cost of the Plan:**

The monthly 2013 premiums are:

(Divide by two if paid twice per month)

<table>
<thead>
<tr>
<th>Level of Coverage</th>
<th>Employee Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0</td>
</tr>
<tr>
<td>Family</td>
<td>$39.14</td>
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<tr>
<td>Double Spouse/Family</td>
<td>$10.02 (each)</td>
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<td>(both Non-Supervisory Merit-Org.)</td>
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Double Spouse Option:

- If both spouse/domestic partner, are actively employed by ISU or the State of Iowa in positions that make them eligible for benefits, they may elect to enroll in a family plan designating one spouse/domestic partner as the contract holder. See details on page 10.
- If you believe you are eligible or need to discuss eligibility, please contact the Benefits Office for appropriate forms and to review options.

Plan Provisions:

The dental plan benefits are divided into four categories - Diagnostic and Preventive Services, Routine and Restorative Services, Major Restorative Services and Orthodontic Treatment.

The maximum benefit for each procedure will be the actual cost charged to the extent that the charge does not exceed Usual, Customary and Reasonable (UCR).

There is a maximum benefit of $1,500.00 except orthodontia, which has a separate lifetime maximum.

- Per covered individual
- Per calendar year
- New hire effective date to end of the calendar year for all services except orthodontia

Once the maximum benefit is used in a benefit year, any additional services will be patient liability.

Limitations may apply for any service, see certificate of coverage or contact Delta Dental Customer Service before approving service.

<table>
<thead>
<tr>
<th>Diagnostic and Preventive Services - Payable at 100% of UCR</th>
</tr>
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<tbody>
<tr>
<td>o Dental Cleanings allowed twice in a benefit period</td>
</tr>
<tr>
<td>o Oral evaluation allowed twice in a benefit period</td>
</tr>
<tr>
<td>o Limitations may apply for any service, see certificate of</td>
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<tr>
<td>coverage before approving service</td>
</tr>
<tr>
<td>o X-rays</td>
</tr>
<tr>
<td>o Once every 12 months – topical fluoride applications, only</td>
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<tr>
<td>for unmarried dependent children under age 19</td>
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</table>

<table>
<thead>
<tr>
<th>Routine and Restorative Services - Payable at 80% of UCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Emergency treatment for relief of pain</td>
</tr>
<tr>
<td>o Fillings</td>
</tr>
<tr>
<td>o Extractions</td>
</tr>
<tr>
<td>o Anesthesia</td>
</tr>
<tr>
<td>o Other basic repair work</td>
</tr>
<tr>
<td>o Space maintainers for children under age 14</td>
</tr>
<tr>
<td>o Topical application of sealants for children under age 15</td>
</tr>
</tbody>
</table>
### Major Restorative Services - Payable at 50% of UCR

- Endodontics
- Non-surgical Periodontal
- Cast Restorations
- Crowns
- Surgical Periodontal
- Bridges
- Dentures

### Orthodontic Treatment – Payable at 50% of UCR

- Available only to dependent children up to age 19
- No deductible
- Lifetime maximum of $1,500.00 per person

### Exclusions:

- Treatments for cosmetic purposes that are unnecessary for dental health
- There may be limitations to procedures listed, refer to certificate located on the Benefits web page

---

**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 62.
The State of Iowa offers the Merit/AFSCME Employees a choice of three (3) types of group medical insurance plans offered by Wellmark Health Plan of Iowa (A Blue Cross/Blue Shield Administrator).

- Program 3 Plus (Classic Blue Indemnity Plan)
- Iowa Select (Alliance Select PPO Plan)
- Blue Access or Blue Advantage (Managed Care Organization, MCO, Wellmark Health Plan of Iowa Network) (WHPI)

**Date Coverage Begins:**

Coverage is effective on the first day of the month following 30 days after the date of employment, providing you enroll prior to your assigned deadline.

**Enrollment:**

*You must complete and turn in an enrollment or waiver form* for your election of the medical insurance plan. If you wish to enroll in Blue Advantage a form is available at the sign up session or from the Human Resources Service Center at 3810 Beardshear, (515) 294-4800 / 877-477-7485. An enrollment form for Program 3 Plus, Iowa Select or Blue Access is included in this packet. You should indicate Program 3 Plus, Iowa Select or Blue Access on the form or sign the waiver section on the form to decline all medical coverage.

Federal legislation requires the names, birth dates and Social Security numbers of dependent spouses and children enrolled for coverage. Please bring this information to the benefits session with you if you plan to complete the enrollment form at the meeting.

If you sign the waiver, you have until your assigned deadline to change your option and enroll in a medical insurance plan. After the initial time, you may be required to wait until the first open change period (see mid-year change).

**Identification Cards:**

- Program 3 Plus, Iowa Select and Blue Access – cards will be issued in the contract holder’s name. Enrolled family participants have identical cards.
- Blue Advantage – cards will be issued, one in each participant’s name enrolled on the contract holder’s policy. In addition, each card will indicate that participant’s Primary Care Physician (PCP) and but will not indicate, if designated, for female participants, the OB/GYN PCP.
Pre-existing Conditions:

Without proof of prior coverage, two plans, Program 3 Plus and Iowa Select, have an 11-month waiting period for pre-existing conditions for anyone over 19 years of age. This means that if you have a health condition which you have been treated for or have had treatment recommended within the past six months, or that a prudent person would seek treatment for, that specific health condition will not be covered for 11-months from the date of coverage. After the 11-month period, all health conditions will be covered. For example: if you are being treated for high blood pressure, no treatment related to that high blood pressure condition will be covered for the first 11-months. After the 11-months, you will have full coverage for all expenses including the high blood pressure condition.

New employees and family members over 19, may receive “credit” toward this 11-month waiting period for any length of time that you have had continuous prior medical coverage provided that the coverage has not lapsed for more than 63 days. This means that every month of prior coverage would give you one month of credit toward the 11-month waiting period. Any COBRA coverage would also be counted as prior coverage.

You may indicate prior coverage directly on the Wellmark form or supply a copy of your “Certificate of Coverage” from your prior carrier. The Certificate must indicate the start and end date of your coverage as well as the start and end date for each of your dependents.

Two plans, Blue Advantage or Blue Access do not have limitations on pre-existing conditions. Eligible claims are covered beginning with your effective date.

Benefits Overview:

The benefit provisions for all plans are compared on pages 21-29. You may use the Provider Information on page 80 to contact any of the vendors.

Program 3 Plus is a Blue Cross/Blue Shield Classic plan. You may seek treatment from any licensed physician anywhere in the world. Benefits will be based on maximum allowable fees for the service area in which the physician practices. If the physician charges more than maximum allowable fee and is not participating with the insurance company, you will be liable for the excess charges. Referral to a specialist is not required with this plan.

Iowa Select is a preferred provider organization (PPO) Blue Cross/Blue Shield Alliance Select plan. If you utilize a physician and/or a hospital participating in the nationwide network, you will be covered by one set of deductibles and co-insurance. If you utilize a non-PPO physician or hospital (out-of-network) or one not contracting with the Blue Cross/Blue Shield Association, you will be covered by a different level of benefits. A list of participating physicians and hospitals is available from Wellmark or accessible on the websites listed on the page 80. Referral to a specialist is not required with this plan.

Managed Care Organization - Blue Advantage or Blue Access, have a choice of either plan in the WHPI network.

- The first category is a “primary care” plan. This plan does require you select a primary care physician (PCP). The PCP will need to refer you to an in-network specialist. Wellmark Blue Advantage is the “primary care” plan. Females may select a separate OBGYN physician.
- The second category is an “open access” plan. This plan does not require a PCP referral. You may self-refer to the providers participating in the network. Wellmark Blue Access is an “open access” plan.
• If you are considering enrolling in Blue Access or Blue Advantage, go to the Wellmark website for a full list of participating providers in Blue Access or Blue Advantage. **REMININDER:** it is your responsibility to ensure that providers you seek services from are participating in the Wellmark Health Plan of Iowa WHPI network. Services received from non-participating providers will NOT be paid by the insurance carrier. *See the 2013 WHPI Service Area Map on page 30.*

• Guest membership: this is an added benefit that must be requested in advance. 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 while away from home for 90 or more consecutive days.

It is important to note: preventative services are not covered unless performed in network by the member’s designated Wellmark Health Plan of Iowa primary care physician. The 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 a guest membership or learn more, contact Wellmark Customer Service, the telephone number can be found on the back of your medical insurance card.

**Cost of the Plans:**

The State of Iowa/Iowa State University pays the full cost of your coverage if you are an employee with single coverage. If you choose family coverage, the State pays the majority of the cost and you pay the remainder.

**Double Spouse Option:**

See details for double spouse option on page 10.

If you believe you are eligible or need to discuss eligibility, please contact the Benefits Office for appropriate forms and to review options.

<table>
<thead>
<tr>
<th>$ Employee Cost $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single Contract – No employee cost</strong></td>
</tr>
<tr>
<td><strong>Double Spouse Contract – No employee cost</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost for active employees family contract</th>
<th>January 1, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program 3 Plus (Classic Blue)</td>
<td>$253.24</td>
</tr>
<tr>
<td>Iowa Select (Alliance Select)</td>
<td>$247.98</td>
</tr>
<tr>
<td>Managed Care Plans</td>
<td></td>
</tr>
<tr>
<td>Primary Care Plan</td>
<td></td>
</tr>
<tr>
<td>Blue Advantage</td>
<td>$0.00</td>
</tr>
<tr>
<td>Open Access Plan</td>
<td></td>
</tr>
<tr>
<td>Blue Access</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
Plan Comparisons
STATE OF IOWA HEALTH BENEFIT COMPARISON

Effective January 1, 2013

This is a limited comparison of benefits. The Summary of Benefit and Coverage are available online, see page 81 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>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</th>
<th>Wellmark BC/BS IOWA SELECT (Alliance Select)</th>
<th>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefits Available From Non-Participating Providers</td>
<td>Normal plan benefits. 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 medical out-of-pocket limit.</td>
<td>Normal plan benefits for select providers. 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 medical out-of-pocket limit.</td>
<td>None, unless prescribed, referred and approved by a participating physician or in an emergency medical condition, or with prior authorization from the Plan (when required).</td>
</tr>
<tr>
<td>Coinsurance Percentage</td>
<td>20%, all services.</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Deductible Single/Family</td>
<td>$300 - single $400 - family Inpatient services only. Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family deductible must be met before benefits payments are made.</td>
<td>$250 - single $500 - family Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of select provider. Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.</td>
<td>$250- single $500 - family Applies to both inpatient and outpatient services. Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.</td>
</tr>
<tr>
<td>Dependent Child Age Limit</td>
<td>-Children through the end of the year in which they turn age 26 regardless of marital status or residency. -Unmarried children over the age of 26 who are full-time students in an accredited institution of post-secondary education. -Unmarried children who are totally and permanently disabled, physically or mentally, regardless of age. The disability must have existed before the child turned age 27 or while a full-time student on the employees plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</td>
<td>Wellmark BC/BS IOWA SELECT (Alliance Select)</td>
<td>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</td>
</tr>
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<td>---------------------------------------------</td>
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<td>---------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Out-of-Pocket Limit (OOP) | Single: $600  
Family: $800  
All deductibles, coinsurance, and copayments, except $15 office visit copayment, go toward out-of-pocket limit.  
Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. The entire family out-of-pocket must be met before benefits payments are made.  
Separate $250 - single $500 - family out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit. | Single: $600  
Family: $800  
Applies to services provided both in-and out-of-network. All deductibles, coinsurance, and copayments except $15 office visit copayment, go toward out-of-pocket limit. Emergency Room copayment continues to apply after out-of-pocket limit is met.  
Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.  
Family: $1,500  
All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.  
Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. |
| Lifetime Benefit Maximum | None. | None. | None. |
| New Employee Preexisting Condition Waiting Period | 11 months.  
No pre-existing conditions for dependents under age 19. | 11 months.  
No pre-existing conditions for dependents under age 19. | No pre-existing conditions. |

YOUR PAYMENT RESPONSIBILITIES

MEDICAL

| Accidents | $15 copay office exam.  
0% coinsurance, no deductible for all treatment within 72 hours of accident. | $15 copay office exam.  
10% coinsurance, deductible waived in office setting. | $15 copay office exam, 20% coinsurance, after deductible. Emergency care covered at in-network level. | $10 copayment office visit. $50 copayment ER, waived if admitted. |
| Allergy Treatment | 20%, no deductible.  
10%, deductible waived in office setting. | 20%, after deductible. | 20%, after deductible. | $10 copayment per visit. |
| Ambulance | 20%, no deductible.  
20%, after deductible. | 20%, after deductible. | 20%, after deductible. | 0%, if medically necessary/emergency medical services. |
<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</th>
<th>In-Network (Select Provider)</th>
<th>Out-of-Network (Non-Select Provider)</th>
<th>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood, Blood Plasma, Blood Serum</td>
<td>20%, no deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td>0%, if authorized.</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>20%, no deductible.</td>
<td>10%, deductible waived in office setting.</td>
<td>20%, after deductible.</td>
<td>$10 copayment if approved provider.</td>
</tr>
<tr>
<td>Dental Accident Care</td>
<td>0%, no deductible for services provided within 72 hours of an accident. 20% thereafter for a maximum of 6 months from injury.</td>
<td>10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.</td>
<td>20%, after deductible. Limited to services provided within 72 hours of accident.</td>
<td>20%, if authorized by Wellmark for injury to sound natural teeth. Services must be within 6 months of injury and injury must have occurred while member enrolled in plan.</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>20%, no deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td>20%, if prescribed by a participating provider and obtained from a supplier authorized by Wellmark.</td>
</tr>
<tr>
<td>Emergency Room (ER Care)</td>
<td>0%, no deductible. Also see section on &quot;Accidents.&quot;</td>
<td>$50 copayment waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.</td>
<td>$50 copayment waived if admitted.</td>
<td>$50 copayment per visit. Limit of one exam per member per year.</td>
</tr>
<tr>
<td>Eye Exam (routine)</td>
<td>Not covered.</td>
<td>$15 copay exam only, 10% coinsurance, deductible waived. Limited to one exam per member per year.</td>
<td>$15 copay exam only, 20% coinsurance, deductible waived. Limited to one exam per member per year.</td>
<td>$10 copayment per visit. Limit of one exam per member per year.</td>
</tr>
<tr>
<td>Hearing Exam (routine)</td>
<td>Not covered.</td>
<td>$15 copay exam only, 10% coinsurance, deductible waived. Limited to one exam per member per year.</td>
<td>$15 copay exam only, 20% coinsurance, deductible waived. Limited to one exam per member per year.</td>
<td>$10 copayment per visit. Limit of one exam per member per year.</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>20%, no deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td>0%, if obtained in a center authorized by Wellmark.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>20%, no deductible. Precertification required.</td>
<td>10%, after deductible. Precertification required.</td>
<td>20%, after deductible. Precertification required.</td>
<td>0% if authorized by Wellmark.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>20%, no deductible. Precertification required.</td>
<td>10%, after deductible. Precertification required.</td>
<td>20%, after deductible. Precertification required.</td>
<td>0% if authorized by Wellmark.</td>
</tr>
<tr>
<td>Immunizations</td>
<td>20%, no deductible.</td>
<td>$0.</td>
<td>10%, deductible.</td>
<td>$0.</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.</td>
<td>$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.</td>
<td>Not covered.</td>
<td>Not covered.</td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>WellmarkBC/BS PROGRAM 3 PLUS (Classic Blue)</td>
<td>Wellmark BC/BS IOWA SELECT (Alliance Select)</td>
<td>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</td>
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<tr>
<td>--------------------------------------------</td>
<td>--------------------------------------------</td>
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<td>---------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Inpatient Physician Services</td>
<td>20%, after deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0%, if authorized.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Room &amp; Board</td>
<td>20%, after inpatient service deductible. No limit on medical surgical days. Precertification of admission required by member.</td>
<td>10%, after deductible. No limit on medical surgical days. Precertification of admission required by select provider.</td>
<td>0% if authorized. Semi-private basis, unless medically necessary to use private room. May require prior approval.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Supplies, Drugs, Medicines, etc.</td>
<td>20%, after deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0% if authorized.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Surgery</td>
<td>20%, after deductible. Must be approved as inpatient procedure.</td>
<td>10%, after deductible. Must be approved as inpatient procedure.</td>
<td>0% if authorized.</td>
<td></td>
</tr>
<tr>
<td>Inpatient Tests, ICU, Operating Room, Specialized Care, etc.</td>
<td>20%, after deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
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<td></td>
<td></td>
<td></td>
<td>0% if authorized.</td>
<td></td>
</tr>
<tr>
<td>Large Case Management</td>
<td>Alternative care set up on a case by case basis by plan.</td>
<td>Alternative care set up on a case by case basis by plan.</td>
<td>Alternative care set up on a case by case basis by plan.</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>20%, no deductible for pre- and post-natal office visits.</td>
<td>10%, deductible waived in office setting for pre- and post-natal visits.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0% for delivery. $10 copayment for initial visit; remaining pre- and post-natal visits paid in full.</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Hospital Room &amp; Board</td>
<td>20%, after deductible.</td>
<td>10%, after deductible.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Inpatient Physician Care</td>
<td>20%, after deductible.</td>
<td>10%, after deductible.</td>
<td>0%.</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Substance Abuse - Outpatient</td>
<td>$0 copayment 0%, coinsurance, deductible waived in office setting for other office services.</td>
<td>$0 copayment 0%, coinsurance, deductible waived in office setting for other office services or independent lab.</td>
<td>$0 copayment. 0%, coinsurance, deductible waived in office setting for other office services or independent lab.</td>
<td></td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</td>
<td>Wellmark BC/BS IOWA SELECT (Alliance Select)</td>
<td>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</td>
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<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Nursing Facility Providing Skilled Care</strong></td>
<td>20%, after deductible. Unlimited days. Precertification required.</td>
<td>10%, after deductible. Unlimited days. Precertification required.</td>
<td>20%, after deductible. Unlimited days. Precertification required. 0%. Maximum of 120 days per member per calendar year.</td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.</td>
<td>10%, after deductible. Prior approval required. Must be a hospital-based billed or as a part of approved home health services.</td>
<td>20%, after deductable. Prior approval required. Must be hospital-based billed or as a part of approved home health services. $10 copayment per visit. Maximum 60 visits per member per year.</td>
<td></td>
</tr>
<tr>
<td><strong>Office Visit</strong></td>
<td>$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. Other services performed in an office setting are 20% coinsurance, no deductible for other office services.</td>
<td>$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. Other services performed in an office setting 10% are coinsurance, deductible waived in office setting for other office services.</td>
<td>$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. Other services performed in an office setting are 20% coinsurance, deductible for other office services. $10 copayment per visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td>Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.</td>
<td>Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.</td>
<td>Heart, heart/lung, lung (single &amp; double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow and allogeneic bone marrow transplants 100% covered if authorized by Wellmark. No coverage if experimental or in non-authorized facility</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Chemotherapy</strong></td>
<td>20%, no deductible. 10%, deductible waived in office setting.</td>
<td>20%, after deductible.</td>
<td>$10 copayment per visit.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery</strong></td>
<td>0%, no deductible. Required for certain procedures.</td>
<td>10%, after deductible. Required for certain procedures. Approval obtained by select provider.</td>
<td>20%, after deductible. Required for certain procedures. 0% if authorized.</td>
<td></td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</td>
<td>Wellmark BC/BS IOWA SELECT (Alliance Select)</td>
<td>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</td>
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<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Outpatient Surgery Setting</td>
<td>Required for certain procedures. Paid according to normal plan benefits when procedure done on outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.</td>
<td>Required for certain procedures. Select provider obtains approval.</td>
<td>Participating physician will determine appropriate surgical setting.</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery Setting</td>
<td></td>
<td>Required for certain procedures. Paid according to normal plan benefits when procedure done on outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicals (routine)</td>
<td>$15 copay exam only. 20%, deductible waived in office setting, for other services. Excludes physicals for travel, employment or athletic related/required. Limited to one physical per member per year.</td>
<td>$15 copay exam only. 10%, deductible waived in office setting for other services. Excludes physicals for travel, employment or athletic related/required. Limited to one physical per member per year.</td>
<td>$10 copayment per visit. Excludes physicals for travel, employment, or athletic related/required.</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>20%, no deductible.</td>
<td>10%, deductible waived in office setting.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td>Preapproval of Inpatient Admissions</td>
<td>Required.</td>
<td>Required.</td>
<td>Required.</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Appliances and Other Devices</td>
<td>20%, deductible waived for participating BCBS providers.</td>
<td>10%, deductible waived.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>20%. Payable inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.</td>
<td>10% after deductible. Must be hospital-based billed or as a part of approved home health services.</td>
<td>20% after deductible. Must be hospital-based billed or as a part of approved home health services.</td>
<td></td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>Voluntary. Paid according to normal plan benefits.</td>
<td>Voluntary. Paid according to normal plan benefits.</td>
<td>Voluntary. Paid according to normal plan benefits when received from plan provider.</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.</td>
<td>10%, after deductible. Prior approval required. Must be a hospital-based billed or as a part of approved home health services.</td>
<td>20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular Joint Treatment(TMJ)</td>
<td>20%, no deductible.</td>
<td>10%, deductible waived in office setting.</td>
<td>20%, after deductible.</td>
<td></td>
</tr>
</tbody>
</table>

- **Outpatient Surgery Setting**
  - Required for certain procedures.
  - Paid according to normal plan benefits when procedure done on outpatient basis.
  - 50% benefit reduction on all associated hospital and surgical services for noncompliance.

- **Physicals (routine)**
  - $15 copay exam only.
  - 20%, deductible waived in office setting, for other services.
  - Excludes physicals for travel, employment or athletic related/required.
  - Limited to one physical per member per year.

- **Physical Therapy**
  - 20%, no deductible.

- **Preapproval of Inpatient Admissions**
  - Required.

- **Prosthetic Appliances and Other Devices**
  - 20%, deductible waived for participating BCBS providers.

- **Respiratory Therapy**
  - 20%. Payable inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.

- **Second Surgical Opinion**
  - Voluntary. Paid according to normal plan benefits.

- **Speech Therapy**
  - 20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.

- **Temporomandibular Joint Treatment(TMJ)**
  - 20%, no deductible.
<table>
<thead>
<tr>
<th>PLAN PROVISIONS</th>
<th>WELLMARK BC/BS PROGRAM 3 PLUS (CLASSIC BLUE)</th>
<th>WELLMARK BC/BS IOWA SELECT (ALLIANCE SELECT)</th>
<th>MANAGED CARE OPEN ACCESS (BLUE ACCESS) &amp; PRIMARY CARE (BLUE ADVANTAGE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WELL CHILD CARE</strong></td>
<td>20%, to 7 years. No deductible.</td>
<td>$15 copay exam only. 10%, to 7 years. Deductible waived in office setting.</td>
<td>$10 copayment per visit.</td>
</tr>
<tr>
<td><strong>XRAY &amp; LAB</strong></td>
<td>20%, no deductible. 10%, deductible waived in office setting.</td>
<td>20%, after deductible.</td>
<td>0%.</td>
</tr>
</tbody>
</table>

**PRESCRIPTION DRUGS**

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>WELLMARK/CATALYST</th>
<th>WELLMARK/CATALYST</th>
<th>WELLMARK/CATALYST</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td>None.</td>
<td>None.</td>
<td>None.</td>
</tr>
<tr>
<td><strong>PHARMACY OUT OF POCKET MAXIMUM</strong></td>
<td>Single $250  Family $500  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. (This out-of-pocket limit is separate from the medical out-of-pocket.)</td>
<td>Single $250  Family $500  Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. (This out-of-pocket limit is separate from the medical out-of-pocket.)</td>
<td>No separate out-of-pocket maximum. Copayments do NOT apply to medical out-of-pocket maximum.</td>
</tr>
</tbody>
</table>

**RETAIL**

<table>
<thead>
<tr>
<th>QUANTITY</th>
<th>30-DAY OR 90-DAY SUPPLY FOR MAINTENANCE AND NON-MAINTENANCE DRUGS.</th>
<th>30-DAY OR 90-DAY SUPPLY FOR MAINTENANCE AND NON-MAINTENANCE DRUGS.</th>
<th>30-DAY OR 90-DAY SUPPLY FOR MAINTENANCE AND NON-MAINTENANCE DRUGS.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREFERRED GENERIC DRUGS</strong></td>
<td>$5.00 copay for 30-day supply or $15.00 copay for 90-day supply per prescription or refill.</td>
<td>$5.00 copay for 30-day supply or $15.00 copay for 90-day supply per prescription or refill.</td>
<td>$5.00 copay for 30-day supply or $15.00 copay for 90-day supply per prescription or refill.</td>
</tr>
<tr>
<td><strong>PREFERRED BRAND NAME DRUGS</strong></td>
<td>$15.00 copay for 30-day supply or $45.00 for 90-day supply per prescription or refill.</td>
<td>$15.00 copay for 30-day supply or $45.00 for 90-day supply per prescription or refill.</td>
<td>$15.00 copay for 30-day supply or $45.00 for 90-day supply per prescription or refill.</td>
</tr>
<tr>
<td><strong>NON-PREFERRED GENERIC AND NON-PREFERRED BRAND NAME DRUGS</strong></td>
<td>$30.00 copay for each prescription or refill. $90.00 copay for a 90-day supply per prescription or refill.</td>
<td>$30.00 copay for a 30-day supply per prescription or refill. $90.00 copay for a 90-day supply per prescription or refill.</td>
<td>$30.00 copay or 25% whichever is greater for a 30-day supply per prescription or refill. $90.00 copay or 15%, whichever is greater, for a 90-day supply per prescription or refill.</td>
</tr>
<tr>
<td>PLAN PROVISIONS</td>
<td>Wellmark BC/BS PROGRAM 3 PLUS (Classic Blue)</td>
<td>Wellmark BC/BS IOWA SELECT (Alliance Select)</td>
<td>Managed Care Open Access (Blue Access) &amp; Primary Care (Blue Advantage)</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Selected Brand Name Drugs</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Mail Order (Maintenance Medications Only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td>90-day supply per copay for maintenance drugs only.</td>
<td>90-day supply per copay for maintenance drugs only.</td>
<td>90-day supply for maintenance and non-maintenance drugs.</td>
</tr>
<tr>
<td>Preferred Generic Drugs</td>
<td>$10.00 copay for each prescription or refill.</td>
<td>$10.00 copay for each prescription or refill.</td>
<td>$10.00 copay for each prescription or refill.</td>
</tr>
<tr>
<td>Preferred Brand Name Drugs</td>
<td>$30.00 copay for each prescription or refill.</td>
<td>$30.00 copay for each prescription or refill.</td>
<td>$30.00 copay for each prescription or refill.</td>
</tr>
<tr>
<td>Non-preferred Generic and Non-preferred Brand Name Drugs</td>
<td>$60.00 copay for each prescription or refill.</td>
<td>$60.00 copay for each prescription or refill.</td>
<td>$60.00 copay for each prescription or refill.</td>
</tr>
<tr>
<td>Selected Brand Name Drugs</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td>30-day supply per copay.</td>
<td>30-day supply per copay.</td>
<td>30-day supply per copay.</td>
</tr>
<tr>
<td>Retail</td>
<td>$15.00 or $30.00 copay for each prescription or refill.</td>
<td>$15.00 or $30.00 copay for each prescription or refill.</td>
<td>$15.00 or $30.00 copay for each prescription or refill.</td>
</tr>
<tr>
<td></td>
<td>Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.</td>
<td>Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.</td>
<td>Copay is based on the drug tier (preferred brand name or non-preferred brand name) the specialty drug is located.</td>
</tr>
<tr>
<td>Mail Order</td>
<td>No mail order benefit available.</td>
<td>No mail order benefit available.</td>
<td>No mail order benefit available.</td>
</tr>
<tr>
<td>Vaccines at the Pharmacy</td>
<td>$15 copay per vaccine, if you have not reached your maximum out-of-pocket.</td>
<td>$15 copay per vaccine, if you have not reached your maximum out-of-pocket.</td>
<td>$15 copay per vaccine.</td>
</tr>
</tbody>
</table>
### Prescription Drug Benefit – General Information

|--------------------------------------------------------------|----------|----------|----------|----------|

| Prescription Drug Coverage – Additional Information | If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay and any difference between the billed charge for the brand name drug and the billed charge for the generic. | If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay and any difference between the billed charge for the brand name drug and the billed charge for the generic. | Not Applicable. |

**Notice for members of Plans underwritten by Wellmark Blue Cross and Blue Shield of Iowa (BC/BS). Your plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BC/BS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the Covered Charge may be satisfied by the BC/BS's payment to the provider plus any amounts the Provider agrees to waive under its contract with BC/BS. Please see your Benefit Certificate for more information.**
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.

### 2013 Wellmark Health Plan of Iowa Areas (Map)*

*All of the shaded Counties are covered by the WHPI network.*
LONG TERM DISABILITY INSURANCE

Participation in the group long term disability (LTD) insurance program is automatic after one year of service for all eligible employees. Principal Life Financial Group is the insurer. A certificate that briefly describes the right and benefits of the long-term disability insurance is located on the benefits web page, www.hrs.iastate.edu/benefits. It outlines what you must do to be insured and it explains how to file claims. This is your certificate while you are insured.

What is Long Term Disability Insurance?

Long term disability insurance is an income replacement. If, for some reason, due to injury or illness, you are unable to perform your normal job duties at ISU, there are coverage benefits you may qualify to receive.

Enrollment / Date Coverage Begins:

During the first year of employment, you may apply for coverage by completing a Principal Statement of Health Questionnaire before your assigned deadline. If coverage for the first year of employment is approved, your insurance will normally be in force on the first day of the calendar month that next follows the date proof is provided by Principal Financial Group.

If you do not apply for coverage in the first year or if your application is denied by Principal Financial Group, you will automatically become covered on the first day of the month coinciding with or following the date you complete one year of continuous active employment, provided you remain eligible during the year.

Enrollment Premiums:

Premium is based on annual budgeted salary.

If you applied for the coverage for the first year of employment and if approved, premium is paid by you on a post-tax basis. After the first year of continuous active employment, Iowa State University will pay 100% of the premium, which will happen automatically.

The premium for the plan coverage is paid in 100% by Iowa State University effective the first of month following the date you complete one full year of continuous active employment, which will happen automatically.
Qualifying for Benefits:

To qualify for Long Term Disability benefits, you must become disabled while insured under this policy and a benefit waiting period applies. For a complete explanation and list of qualifications see the Summary Plan Document / Long Term Disability Booklet/Certificate, which is available on the Benefits website at http://www.hrs.iastate.edu/hrs/benefits/.

Policy Benefits:

Income:
The amount of benefit is based on your University budgeted salary. Monthly compensation is 1/12 of annual budgeted salary. The benefit will be the sum of:

- 75% of the first $1,000 of monthly compensation at the time your disability begins, plus
- 60% of your monthly compensation in excess of $1,000
- Up to a maximum benefit payable of $7,650 per month
- Cost of living adjustments based upon the Consumer Price Index are applied to benefits each year on the July 1 following completion of one year of continuous disability.
- Benefit payments are coordinated with Primary and Dependents Social Security and Workers’ Compensation benefits.

Life Insurance:
Participants maintain full value of Iowa State University life insurance policies enrolled in at the time of the disability incurred date. Premiums are paid through life waiver.

Health and Dental Insurance:
Disability participants have the option to continue group health and dental insurance, but employee is responsible for the full premium. There will be no Iowa State University contribution.

Waiver of Annuity Contribution Benefit:

If you are enrolled in the TIAA-CREF Retirement Program or VALIC (not IPERS) and qualify for benefit payments under the Long Term Disability policy, your standard contribution and Iowa State University’s contribution to the TIAA-CREF Program / VALIC will be continued by Principal Financial Group during the period of your disability. Contributions will continue as long as you are receiving Long Term Disability benefit payments. Contributions will end when benefit payments end.

University Extension employees under a Federal Retirement Program (Civil Service or FERS) are also covered under this benefit. At the time of disability, a TIAA-CREF contract will be established to accept the waiver contributions.

Cost of living adjustments are also included in the Waiver of Annuity Contribution benefit

Participants with IPERS will not have waiver contributions.
Termination of Benefits:

Long Term Disability payments cease on the earliest of:

- the date of your death
- the day before the date of your retirement
- the date you are no longer disabled, or you fail to submit to any required examination
- the June 30 following the date you attain age 65 if your disability begins before you are age 61
- the earlier of five years or June 30 following the date you attain age 70 if your disability begins after age 61, but before age 69
- after 12 months of benefit payments if your disability begins after age 69
- the date you cease to be a participant in the TIAA-CREF; or the Civil Service Retirement System (CSRS); or the Federal Employees Retirement System (FERS), or VALIC
- the date you fail to report income from other sources

For a complete list of reasons for termination, refer to Group Disability Insurance Certificate which is available on the benefits website.
Basic Life / AD & D Insurance

The Basic Life Insurance Program at Iowa State University is an optional benefit. Eligible employees may either accept or decline the coverage. **You may purchase coverage for yourself only - dependent coverage is not available.** Principal Financial Group is the insurer.

A Summary Plan Document/Group Life Insurance Booklet-Certificate of Coverage that briefly describes the right and benefits of the life insurance located on the benefits web page, [http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits). It outlines what you must do to be insured and explains how to file claims. This is your certificate while you are insured.

**Date Coverage Begins:**

Coverage is effective on the first day of the month coinciding with or following the date of employment, providing you enroll by your assigned deadline.

**Cost of the Plan:**

The cost of the Basic Life Insurance is shared by you and the University. Your cost is $.05 per month per $1,000 of Basic Life Insurance coverage. The University pays the balance of the premium cost for the Basic Life Insurance. The University also pays the entire cost of Accidental Death and Dismemberment (AD&D) coverage provided you are enrolled in the Basic Life Insurance.

**Policy Benefits:**

- Term Life Insurance of two (2) times your University budgeted salary rounded to the nearest $1,000.
- Accidental death insurance of four (4) times your University budgeted salary rounded to the nearest $1,000. This is in addition to the Basic Term Life coverage above.
- Accidental dismemberment coverage between 1/2 and the full amount of your University budgeted salary.
  - There are additional benefits included with AD & D, refer to Summary Plan Document/Group Life Insurance Booklet-Certificate located on Benefits web page: [http://www.hrs.iastate.edu/hrs/benefits](http://www.hrs.iastate.edu/hrs/benefits).
- Waiver of continued premium payments in the event of total disability:
  - Value at the time of disability will continue until June 30, following your 65th birthday.
  - Value will continue reduced by 65% until you no longer meet the definition of disability or when you turn age 70, whichever occurs first.
  - No benefits will be paid for any disability that results from willful self-injury, or self-destruction, while sane or insane/war or act of war/voluntary participation in an assault, felony, criminal activity, insurrection or riot.
- The basic life insurance policy is not a portable plan. Terminating employees are offered a conversion application.
- Retiree Life Insurance coverage of $4,000 is available, if enrolled for 10 consecutive years, immediately preceding retirement.
- Employees who continue active employment after age 65 will have benefits reduced to 65% January 1st the year of your attainment of age 65. The employee share will be reduced accordingly on January 1st. The premium cost will be reduced accordingly.
- This is term insurance and thus does not provide for a cash surrender value.
Enrollment:

You must complete and turn in the ISU Group Life Insurance enrollment form to elect or waive coverage.

You will have until your assigned deadline to enroll in the Life Insurance plan. If you decline the Life Insurance by your assigned deadline, you may only apply for coverage during the annual open change period with a Principal Statement of Health Questionnaire that must be approved by Principal Financial Group before coverage will begin.

Beneficiary Election:

If electing coverage, primary beneficiaries should be listed on the beneficiary form. If you list more than one primary beneficiary, the payable benefits will be divided by percentage between the named beneficiaries as you specify.

Contingent beneficiaries should also be listed on the beneficiary form. Contingent beneficiaries receive benefits only if all primary beneficiaries are deceased.

If any of the beneficiaries are minors, under age 18 according to the Uniform Transfers to Minors Act, a custodian for such beneficiary should be named on the beneficiary form for the proceeds to be payable to the beneficiary.

You may change the beneficiary designation at any time during the year:

- The beneficiary change forms are available on the Benefits Office website under employment classification and then under the section of “Life”.

- Contacting Human Resources Service Center in 3810 Beardshear Hall or via phone 515-294-4800 / 877-477-7425.

- Beneficiary change form must be returned to 3810 Beardshear for processing. Do not send to Principal Financial Group.
Voluntary Life Insurance

Principal Financial Group is the insurer for the Voluntary Life Insurance. In addition to Basic life insurance/AD&D, you may purchase additional 1, 2, 3 or 4 times your budgeted annual salary (rounded to the nearest $1,000) in Voluntary Life Insurance. The plan requires that you enroll in Basic Life/AD&D in order to purchase the Voluntary Life Insurance coverage.

Date Coverage Begins:

If you elect the benefit of 1 or 2 times of your annual salary prior to your assigned deadline, it will become effective the first of the month following your hire date. Coverage for the levels of 3 or 4 times of your annual salary will be effective date upon notification of approval from Principal Financial Group. If denied the level of 3 or 4 times, your coverage will be at the 2 times level.

Coverage Options / Premium Payment:

You have four options for Voluntary Insurance Coverage:

- 1 times your budgeted annual salary (rounded to the nearest $1,000)
- 2 times your budgeted annual salary (rounded to the nearest $1,000)
- 3 times your budgeted annual salary (rounded to the nearest $1,000)
- 4 times your budgeted annual salary (rounded to the nearest $1,000)

The premium rates for Voluntary Life Insurance are based on your age and your budgeted annual salary.

You pay for Voluntary Life Insurance coverage with post-tax dollars. Your premiums are automatically deducted from each payroll throughout the year.

Coverage for the levels of 1 or 2 times:

- If enrolled prior to your assigned deadline will have guaranteed enrollment.

Coverage for the levels of 3 or 4 times:

- You are required to provide evidence of insurability by completing the Principal Statement of Health Questionnaire.
- The effective date would be upon notification of approval from Principal Financial Group.
- Effective date for coverage requiring completion of a statement of health will be upon notification from Principal Financial Group.

Minimum: Greater of 1 times your salary or $10,000
Maximum: Lesser of 4 times your salary or $500,000

Guaranteed coverage under age 70: the lesser of 2 times your salary or $500,000
Guaranteed coverage over age 70: the lesser of 2 times your salary or $10,000
**Premiums:**

To calculate rate: round your annual budgeted salary to the nearest $1,000, multiply by the level of coverage you are applying (1, 2, 3 or 4 times your salary), then divide by $1,000 and multiply the cost of your age group. Premiums are paid with post-tax dollars. The age group will change on January 1 of the year your age will change you into the new group. Premiums are paid with post-tax dollars. These rates are subject to change, you should review them during the open change period.

<table>
<thead>
<tr>
<th>Age</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 29</td>
<td>$0.08</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.09</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.11</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.15</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.23</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.35</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.55</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.84</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.43</td>
</tr>
<tr>
<td>70 &amp; over</td>
<td>$3.75</td>
</tr>
</tbody>
</table>

**Enrollment:**

To enroll in Voluntary Life Insurance, calculate your monthly premium cost by using the formula indicated on the Long Term Disability & Life Insurance Enrollment Form and circle the level of coverage. You must also complete the Principal Financial Group Employee Enrollment & Waiver – IA form.

If you waive coverage, you can only add coverage at a later date through an approved Principal Statement of Health Questionnaire during the annual open change period.

**Beneficiary Designation for Voluntary Life Insurance:**

The beneficiaries you designate for your Basic Life/AD&D coverage will also be the beneficiaries for your Voluntary Life Insurance unless you complete additional forms to designate different beneficiaries for your Voluntary Life Insurance. You have the right to make future changes to your beneficiary designation. If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to employee Minors Act section of the beneficiary designation form.

**Portability:**

When insurance coverage terminates as an active employee, you may be eligible to continue insurance under a Group Life Portability Insurance Policy underwritten by Principal. The Group Life Portability Policy will contain provisions that differ from the Group Policy. You will have the option to continue the insurance coverage under this option. If coverage is ported, there a several reasons the coverage would terminate, review the Summary Plan Document (found on Benefits web page) for the details.
Coverage During Disability:

If you become totally disabled before age 60, coverage will continue and premium will be waived for you. You must be totally disabled for 9 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 70, whichever occurs first. No benefits will be paid for any disability that results from willful self-injury, or self-destruction, while sane or insane, war or act of war, voluntary participation in an assault, felony, criminal activity, insurrection or riot.

Accidental Death & Dismemberment:

You receive an additional benefit equal to your Voluntary Term Life Insurance amount for loss of life, hands, feet or vision as the result of an accident. Coverage includes payment for injuries arising from or during employment for wage or profit for insured employee. The loss must occur within 365 days of the accident. There are several other benefits included with AD&D.
EMPLOYEE ASSISTANCE PROGRAM (EAP)

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?

In-person counseling sessions – You’ll receive up to three sessions per year, per separate issue, with a masters or doctorate level counselor near your work or home. Your counselor will help you to better understand and to develop a plan for responding to any of your life stressors. There is the service of telephone counseling available 24/7 with unlimited number of calls.

EAP life coach – You’ll have access to eight weeks of web-based and telephone coaching with a certified life coach, who will support, encourage and guide you towards self-determined goals. The service includes telephone and web based interaction with the Coach, access to articles assigned by the Coach, and the opportunity to record thoughts and experiences in a personal web journal.
**Legal Consultation** – Your EAP will refer you to an attorney in your area for a free 30-minute telephone or in-person legal consultation for any non-employment related legal issue. A 25% reduction in attorney fees is available if you choose ongoing representation.

**Eldercare Consultation** – An EAP counselor will help you locate and access resources to assist with the caregiving of your elderly parents or other dependent adults for whom you provide caregiving either locally or long distance.

**My Guide Membership** – For life planning, you can access on your EAP website, a workbook, personal planning assessment tool, hundreds of articles and more.

**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](http://www.efr.org/wps/eap)
Iowa State University offer a voluntary group eyewear insurance plan to all eligible, actively-at-work employees and eligible family members. The eyewear plan vendor is called Avesis Vision.

The Avesis plan does not cover eye exams. Exams may be covered under your medical plan.

The Avesis plan will allow access to one of the most competitive vision networks in the nation. Avesis contracts with independent optometrists, ophthalmologists and most retail chain centers making it convenient for employees to purchase glasses or contacts at locations close to where they live or work.

**Date Coverage Begins:**

Coverage is effective on the first day of the month coinciding with or following the date of employment, providing you enroll by your assigned deadline.

**Enrollment:**

Complete the enclosed Avesis Enrollment form and turn in prior to your assigned deadline.

**Cost of the Plan:**

Monthly premium deducted on a post-tax basis:

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013 Premiums</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Employee</strong></td>
<td>$6.98</td>
</tr>
<tr>
<td><strong>Employee + Spouse</strong></td>
<td>$13.23</td>
</tr>
<tr>
<td><strong>Employee + Child(ren)</strong></td>
<td>$14.42</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>$18.55</td>
</tr>
</tbody>
</table>

A complete listing of providers in Iowa and the United States can be found:

- [www.avesis.com](http://www.avesis.com)
- 800-828-9341 to contact Avesis Customer Service Representatives
- Use group #60790-1227 and
- Plan #9133 to identify our plan
Want more information?

Detail information regarding the Avesis vision plan design can be found at: [https://www.Avesis.com/isu/](https://www.Avesis.com/isu/);

1. Click on “What is Covered”

2. Find this picture link to view the complete summary of benefits
PREMIUM CONVERSION PROGRAM

Eligible employees will automatically be enrolled in the Premium Conversion program unless they indicate that they do not wish to participate. If you participate in Health Care Flexible Spending Account or Dependent Care Assistance Program, Premium Conversion is required.

**Date participation begins:**

Participation begins when your first medical, dental or life insurance premium is deducted from your payroll. You have until your designated deadline to decline participation in the program.

**Benefit:**

With the program, employees pay their share of the medical, dental and life insurance premiums with pre-tax rather than post-tax salary dollars. Enrollment in this program will result in higher take-home pay because of lower Federal and State Income Tax and Social Security Tax.

Enrollment in this program does mean that the medical and dental premiums are not eligible to include as itemized medical tax deductions. However, it means that you gain immediate and assured tax deductibility, rather than tax deductibility only if you itemize and then only if the incurred medical and dental expenses exceed 7.5% of your adjusted gross income.

**Limitations:**

Section 125 of the Federal Internal Revenue Code governs how employees enroll and make changes in this program. Employees may make elections on an annual basis, during a designated “Open Change Period”. Once this election has been made, it cannot be changed for the remainder of the plan year (January 1 through December 31) unless there is a change in **Family Status**, i.e. marriage, divorce, birth, adoption, death, employment change, etc. This means that if you participate in the Premium Conversion Plan with a family medical and/or dental contract and later in the year decide that you wish to change to a single contract, in the absence of a “Family Status” change, you would not be able to make the change. Likewise, if you enroll in a single contract and the Premium Conversion Plan, you may not change to a family plan during the year except within 30 days of a “Family Status” change.

You also need to be aware that enrollment in the Premium Conversion Plan reduces the Social Security Tax that is withheld, so your Social Security benefits at retirement may be slightly reduced. Enrollment in this plan will not affect contributions to your basic retirement plan.

**Election:**

The default is to participate in the Premium Conversion program. You will continue to participate unless during an open change period you complete a form indicating that you wish to opt out of the program.

If you wish to initially decline the Premium Conversion program, check the box I decline to participate on the enrollment form. If you decline to enroll in the program at this time, and wish to do so at a later date, you may enroll during an annual open change period. A “family status change” as defined above will not enable you to enroll in the program mid-year.
Coverage Plan Year:

The State of Iowa’s plan year is from January 1 through December 31. Each year the University has an enrollment period for the Premium Conversion program. During this period Iowa State University may choose to default existing employees to the pre-tax premium conversion program. Each year you may:

- Elect in the Premium Conversion program (if previously declined)
- Elect to discontinue enrollment in the Premium Conversion program even if ISU is defaulting participants.
What are Flexible Spending Accounts?

The health care flexible spending account (FSA) & dependent care assistance program (DCAP) help you save money on health and dependent care (typically child care) expenses that you are already incurring. Use these accounts to leverage your household’s savings. By contributing a portion of your paycheck into an FSA or DCAP on a pre-tax basis, you may save from 25% to 40% on the cost of eligible expenses you are already incurring.

The FSAs are tax-free account that allow:

- Expenses you pay for essential health care expenses that are not covered, or are partially covered, by your medical/prescription drug, dental and vision insurance.
- Expenses you pay for child/dependent care expenses including day care, babysitting, in-home care for older dependents and before & after school care.

Date Participation Begins:

Participation begins the first day of the first full month of pay, provided you enroll prior to your assigned deadline.

The initial enrollment covers expenses incurred from the first day of the month in which the first deduction is taken through December 31. For example: Hired August 15th, paid in August but first full pay month is September and the first deduction for flex is on September 30th which will be available for expenses incurred from September 1st.

Participation Changes:

Once a spending account is elected the employee contribution will continue year after year unless the employee makes a change during the open change period.

Enrollment Information:

To newly enroll in the FSA or DCAP, complete the enrollment form and return it to the Human Resources Service Center, 3810 Beardshear Hall prior to your assigned deadline.

If you do not wish to enroll in the FSA or DCAP programs, check the “decline” options on the enrollment form.

If you do not enroll in the FSA or DCAP programs at this time, and wish to do so at a later date, you may enroll during an open change period. For DCAP, you may also enroll with a qualifying event.
**Annual re-enrollment is not required.** If you enroll in either flexible spending accounts, your own current contribution will automatically become the next plan year January 1 to December 31 election. During the annual open change period you are required to review and take action if you want to start, stop, increase or decrease the employee current election.

Health Care Flexible Spending Account (FSA)

- If you decide to enroll, estimate anticipated out-of-pocket medical, prescription drug, dental and/or vision expenses for the plan year (effective date through December 31).
- If you do not incur expenses for the full amount during the plan year (effective date through December 31), Federal regulations mandate that remaining funds may not be refunded to the employee. Iowa State University uses forfeited funds to help defray the administrative costs of the plan.

Dependent Care Assistance Program (DCAP)

- If you decide to enroll, estimate anticipated dependent care expenses for the year (effective date through December 31).
- If you do not incur expenses for the full amount during the plan year (effective date through December 31), Federal regulations mandate that remaining funds may not be refunded to the employee. Iowa State University uses forfeited funds to help defray the administrative costs of the plan.

**Contributions:**

When you enroll in the FSA and/or DCAP, Iowa State University will deduct the amount you designate from your pay in pre-tax dollars (those employees paid 2 times a month will have ½ of the monthly contribution deducted from the mid-month check and the other ½ from the last check of the month).

ISU requires a minimum contribution of $20 per month.
- For FSA, ISU allows you to participate up to the IRS maximum contribution limit of $2,500.00 per year
- For DCAP, ISU allows you to participate up to the IRS maximum contribution limit of $5,000.00 per year; per tax household. The amount you contribute to your spending account is tax exempt.

**Example:** $416.66 per month = $4,999.99 for a 12 month pay.

**You will not pay Federal or State Income tax or Social Security or Medicare tax on this money.**

These funds are reimbursed to you when you file the claim for your eligible out-of-pocket medical/prescription drug, dental and/or vision expenses or dependent care expenses.

**Changing Your Elections:**

Once you have made your FSA and/or DCAP elections for the plan year, you may not change your elections except within 30 days of a “family status change” and changes must be compatible to the event. The Internal Revenue Service specifically defines a “family status change” as:
- Marriage
- Divorce
- Death of your spouse or dependent
- Birth or adoption of a child
- Change in child custody
- Change in you or your spouse’s employment status
A family status change, however, will **not allow** you to enroll in the FSA during the plan year, only to change the contribution election you made during the enrollment period. The change must be consistent with the family status change.

However, for the DCAP, a qualifying family status change **does allow** you to enroll or make a change in the account during the plan year. The change must be consistent with the family status change.

If you qualify to change your elections due to an event, contact the Human Resources Service Center at 515-294-4800 or at 877-477-7485 and ask to speak to the Benefit Consultant to obtain the appropriate form. Remember you must do this within the 30-day time frame.

**Making Calculations:**

If you decide to enroll in the FSA, estimate anticipated out-of-pocket medical, prescription drug, dental and/or vision expenses for the year. If enrolling in the DCAP, estimate anticipated dependent care expenses for the year.

Using the FSA to pay for expenses will reduce your out-of-pocket costs significantly. Your personal tax rate may vary, and your savings will vary according to your net tax rate. Use the Tax Savings Calculator found at [http://isu.asiflex.com](http://isu.asiflex.com) to estimate your savings.

The total must be divided evenly by the number of months you are paid (employees whose annual budgeted salary is paid on a 9 or 10 month basis will have 10 equal deductions).

Use care in estimating expenses! If you do not incur expenses for the full amount during the plan year (effective date through December 31), federal regulations mandate that remaining funds **may not be refunded to the employee.** Iowa State University uses forfeited funds to help defray the administrative costs of the plan.

**Reimbursement Process:**

ASIFlex will process Iowa State University employee reimbursement requests. Reimbursements for the calendar year will not begin until the first payroll contributions are reported - submit claims after that date. You will have until April 30 of the next calendar year to submit a reimbursement request for qualified previous plan year expenses.

The FSA and DCAP are two separate accounts. If you have funds remaining in one account at the end of the plan year, those funds cannot be transferred to the other account.

Funds are reimbursed to you when you file a claim for yourself and any eligible dependents.

**Claim Submission Options:**

- **Online** – [https://my.asiflex.com](https://my.asiflex.com)
  Submitting your claim online is easy and convenient! In order to submit your claim via ASIFlex’s secure online portal, you will need your PIN, which was provided to you in your welcome packet and in each account summary statement. If you do not have your PIN, you may call Customer Service at 800-659-3035. Once you are inside the portal, you are allowed to use your University ID to access your account.
• Toll-free fax - 877-879-9038
  This option provides easy and fast claims submission. You may submit your claim via ASIFlex’s toll-free fax number 24 hours a day, 7 days a week.

• US Mail
  P.O. Box 6044, Columbia, MO 65205
• Additional claim forms may be obtained by visiting http://isu.asiflex.com.

How will I receive reimbursement?

• Go Paperless! Sign up to receive notifications from ASIFlex via email, rather than US Mail. By signing up for email notification, you will receive reimbursement notifications, account summary statements and more within one day of processing. Online Account Detail and the Secure Message Center are available 24 hours, 7 days a week at https://my.asiflex.com. Complete history, including available funds, year-to-date contributions, year-to-date reimbursements and more are available at online account detail. You will need your Flexible Spending Account PIN in order to access https://my.asiflex.com. Your PIN was provided to you in your welcome packet. If you do not have your PIN, you may call Customer Service at 800-659-3035 to obtain this number.

• Sign up for direct deposit today! By electing to receive reimbursements via direct deposit, you will receive your money up to 5 days faster than waiting for a check to be mailed to your home address. If enrolled in direct deposit, due to Federal banking regulations the effective date of the deposit is typically the banking day following the release of payment of the claim by ASIFlex. Direct deposit enrollment forms can be found at http://isu.asiflex.com, or by calling customer service.

Leaving ISU

The FSA and DCAP accounts are active employee benefits. If you terminate your employment with Iowa State University, your contribution into either of the flexible spending accounts will terminate at the end of the month in which your employment ends.

• DCAP does not have a COBRA option.

• You may elect COBRA coverage for the FSA. This option allows you to extend your period of participation on a monthly basis up to the remainder of the plan year, but tax savings is eliminated. If you elect COBRA you pay the monthly contribution and an administration fee.
  
  o A COBRA application will be mailed to your home address to continue the FSA.

• Without COBRA, you may request reimbursement only for charges for services incurred prior to your plan termination. You must request reimbursement by April 30 of the following year.
HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care Flexible Spending Account (FSA) is an optional program. Eligible employees may either enroll or decline participation in the program. Eligible employees must participate in the Premium Conversion Program to participate in the FSA.

The Health Care FSA is a reimbursement account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, dental and vision insurance plans with money that is deducted from your payroll pre-tax.

The key to getting the most out of your Health Care FSA is to maximize your contributions based on the expenses you, or any of your tax dependents, anticipate incurring during the plan year. To plan your annual election amount:

1. Review the list of Eligible Expenses.
2. Review your medical expenses from last year.
3. Estimate expenses base on new ISU coverage.
4. Be sure to include at least some money to cover your deductible or out-of-pocket expenditures.
5. Estimate your cost for each of these FSA eligible expenses. (Don't forget that your tax dependents' expenses qualify, too, even if they are on a different health insurance program.)

Things to Remember About the FSA:

- Your election amount is typically fixed for the entire plan year (unless you have a qualifying event).
- When calculating your expenses, you should include only predictable expenses.
- You may include expenses for yourself, your spouse, or your qualified tax dependents, including adult children (through December 31 of the calendar year in which he or she turns age 26).

For detailed information regarding health care flexible spending account go to the ASIFlex website: http://isu.asiflex.com/default.html

- Medical Expense Estimator
- Review Frequently Asked Questions
- Eligible Expense List Includes
  - Medical Expenses
  - Potentially Eligible Expenses
  - Not Eligible Expenses

Should I Enroll in a Health Care Flexible Spending Account?

Eligible health and dental expenses may be itemized on your annual tax return. The itemized expenses are only deductible to the extent they exceed 7.5% of your adjusted gross income. Participation in the FSA ensures that all eligible expenses you claim will be tax exempt.

You must be able to reasonably estimate your expenses prior to the start of the plan year.
For example: you may have an $800 out-of-pocket maximum for your medical plan and elect to contribute $67.00 a month ($804.00) into your Health Care Flexible Spending Account.

If you do not incur the total expense prior to December 31st or claim all $804 in out-of-pocket expenses by April 30, you will forfeit any remaining balance.

**PLEASE REMEMBER** that your participation in the FSA reduces your wages for social security and Medicare tax withholding and may reduce eventual social security benefits.


Eligible expenses must be incurred during the plan year (effective date through December 31 or prior to your termination of employment).

The determining factor is the actual date of services, not the date of billing or the date the bill is paid.
The Dependent Care Assistance Program (DCAP) is an optional program. Eligible employees may either enroll or decline participation in the program. Eligible employees must participate in the Premium Conversion Program to participate in the DCAP.

Please note that future or projected expenses cannot be reimbursed until services have been rendered.

Most work-related expenses incurred during the plan year for the care of a qualified person (a qualified person must be either a Qualifying Child or a Qualifying Relative as defined by the IRS) will qualify for non-taxable reimbursement through a DCAP. Any expense that would qualify under Internal Revenue Code section 21 for the Child Care Credit will qualify for reimbursement. Please refer to Internal Revenue Service Publication 503 for more information.

Dependent care expenses are incurred when the services are provided and not when you are billed for or pay for those services.

GENERAL REQUIREMENTS:

1. It will be the responsibility of the employee to claim the funds; any unclaimed funds will be forfeited.
2. The Dependent Care Assistance Program (DCAP) is an optional program. Eligible employees may either enroll or decline participation in the program.
3. Your child/dependent care expense must be incurred to allow you and your spouse, if married, to work or look for work.
4. The provider of the child/dependent care must be someone you or your spouse could not claim as a dependent and if the provider was your child then he/she must have been 19 or older by the end of the year.
5. You must supply the provider's name and address and a receipt or the provider’s signature and date in place of receipt.

Go to the ASIFlex website, [http://isu.asiflex.com/default.html](http://isu.asiflex.com/default.html) for detailed information regarding:

- Work-Related Expenses
- Work Requirements – for part-time employment, students etc.
- Keeping Up A Home
- Expenses For Household Services
- Expenses For The Care Of A Qualifying Person
- Qualifying Persons
- Limitations and Reimbursements
- Eligible and Ineligible Dependent Day Care Expense Listing
- Dependent Day Care General Information

Should I Enroll in a Dependent Care Assistance Program?

Deciding whether to use the DCAP the Federal or State Dependent Care Tax Credits can be complicated.

As a general rule, it may be advantageous to take the dependent care tax credit.

- If your family’s adjusted gross income is higher than $39,000, or
• Your tax rate is 28% or higher, or
• You have one dependent and dependent care expenses exceed $2,400
• If your annual adjusted gross household income is less than $39,000

For assistance, consult your tax advisor.

You cannot apply dependent care costs reimbursed through the DCAP to the Federal Income Tax Credit for Child and Dependent Care. Furthermore, every dollar used in the Spending Account reduces the amount you can apply toward the Federal Tax Credit by one dollar.

For example, if you have two or more children and your total care costs are $4,800 per year, if you use the Spending Account for $300 per month or $3,600 for the year, you would still be able to use the remaining $1,200 ($4,800 - $3,600) as a tax credit. If you use the Spending Account for $416.66 per month or the full $5,000 for the year, you would not be able to claim the Tax Credit.

Note: Employees and their spouses with combined net incomes of $40,000 or more cannot claim Iowa tax credits for dependent care expenses on their State income tax returns. The only way to reduce state tax on those expenses is through the use of the DCAP.
Introduction to ISU Retirement Funds

Eligibility Requirements:

Iowa State University employees are employees of the State of Iowa. State employees are required by law to participate in a retirement program while they work for the state.

University employees who are classified as employees are required to participate in IPERS unless they are eligible for and elect participation in TIAA-CREF or VALIC. Appointment of two calendar quarters or longer triggers the required participation in IPERS. Shorter, non-recurring appointments are not subject to this requirement.

You are eligible for TIAA-CREF or VALIC when your budgeted salary is $7,800 or more per year and you have an appointment of 1/2 time or more for 9 months or longer.

Exceptions to this requirement are foreign nationals in this country on F-1, F-2, J-1 and J-2 visas. Employees in these visa statuses may elect participation in TIAA-CREF but are not required to be in any retirement program. If you are now eligible to enroll in TIAA-CREF, but chose not to because you are not required to do so in your current visa status (F-1, F-2, J-1, J-2), that decision is irrevocable. A later change in your visa status, which would require participation in a retirement program, would place you into the IPERS program even though you were otherwise eligible to be in TIAA-CREF. A waiver of enrollment must be signed, request from Benefits Office.

Without an appropriate election, by default you will be irrevocably placed in IPERS during your employment with Iowa State University.

Election Period:

The election to participate in one of the University sponsored retirement programs is available until your assigned deadline date. If no election is made prior to your assigned deadline, you will remain in IPERS during your employment at Iowa State University and this default is irrevocable.

Effective Date:

Your date of appointment is your effective date, if you meet the eligibility requirements at that time. You must enroll by your assigned deadline of your eligibility otherwise you will be irrevocably excluded from participation in TIAA-CREF and be defaulted to IPERS.

Retirement Plans offered:

- Defined Benefit Pension Plan – IPERS
  
  *Iowa Public Employees Retirement System*

  This is a defined benefit plan that makes the investment decision as a group; annuity is based on a formula.

- Defined Contribution Retirement Plan (403b) - TIAA-CREF
The Teachers Insurance and Annuity Association (TIAA)
College Retirement Equities Fund (CREF)

- Defined Contribution Retirement Plan (403b) – VALIC
  The Variable Annuity Life Insurance Company

These are defined contribution retirement plan bases benefits on the retirement income option you select, your age at the time benefits begin, the size of your retirement plan accumulations and the accounts rate of return before and after retirement. The plan’s primary purpose is to pay you a lifelong income after you retire.

Enrollment:

To enroll in a University retirement plan, you will need to complete:

**Iowa State University Retirement Plan Election Form**
Print your name and Social Security number in the space provided in the first paragraph. Check the box indicating your wish to enroll in IPERS, TIAA-CREF, or VALIC. Your election date will be your first day of work. Please sign, date the form, and complete application of choice.

AND

**IPERS Membership Information and Beneficiary Designation**
Your employer is Iowa State University. You will be a considered a new member, unless you were enrolled in IPERS at a previous job and did not “cash out”. Complete your Social Security number, date of birth, gender, name, address, and telephone. Indicate your beneficiary election. Examples are on the back of the form. Please sign and date the form in front of a witness, whose signature is also required.

OR

**TIAA-CREF Application Form**
Complete application from TIAA-CREF packet or on-line following your benefit session. When applying on-line, please refer to the flyer included in this booklet for step-by-step instructions.

**VALIC**
To enroll in VALIC you will need to contact VALIC at 913-402-5000 (District) or 515-770-1725 (Cellular)

Contact Information:

**TIAA-CREF Office** - Representatives of TIAA-CREF are available by appointment only for free financial services. Their office is located at 2713 Stange Road, Ames, IA 50011. Appointments can be set up through their website: [www.tiaa-cref.org](http://www.tiaa-cref.org) or by calling 800-732-8353.

**VALIC** - Contact VALIC Retirement agent, Daniel Allen 913-402-5000 (District) or 515-770-1725 (Cellular) or [www.valic.com](http://www.valic.com).

**IPERS** - [www.ipers.org](http://www.ipers.org) or call 800-622-3849.
<table>
<thead>
<tr>
<th>Plan Comparisons</th>
<th>IPERS</th>
<th>TIAA-CREF and VALIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Definition</strong></td>
<td>The IPERS plan is a defined benefit plan. The benefits at retirement are determined by a formula of years of service and an average based on salary. Defined benefit plans are sometimes called traditional pension plans.</td>
<td>TIAA-CREF and VALIC are types of defined contribution plans (403b). The amount contributed to the plan is defined, but your benefit at retirement is not.</td>
</tr>
<tr>
<td><strong>Plan Design</strong></td>
<td>The rules governing the operation of IPERS are controlled by the Iowa legislature. Changes are communicated by IPERS directly to members.</td>
<td>Established by Iowa State University (ISU) and approved by the State Board of Regents. The design is subject to change. Any change is communicated to members by ISU.</td>
</tr>
<tr>
<td><strong>Who Takes on Investment Risk</strong></td>
<td>IPERS takes on all the investment risk. The amount of your benefit is not affected by fluctuations in the investment marketplace.</td>
<td>You, the employee, take on the risk. You are responsible for deciding how to invest your money and monitoring ongoing investment performance. Your investment options are described in the booklet “Building your Portfolio with TIAA-CREF” contained in this packet.</td>
</tr>
<tr>
<td><strong>Guaranteed Benefit</strong></td>
<td>Yes. You receive a guaranteed lifetime benefit. You can’t outlive your benefit.</td>
<td>Benefit is dependent on plan choice. The amount of your benefit can fluctuate up and down based on the performance of the investments you select. TIAA-Cref - one choice option has a guaranteed benefit – The Traditional Annuity. The plan’s primary purpose is to provide lifelong income after you retire. See VALIC agent for VALIC options.</td>
</tr>
<tr>
<td><strong>Benefit Amount</strong></td>
<td>You receive a predictable benefit, calculated using a set formula. <strong>Current Retiree:</strong> Multiplier is 2% a year for first 30 years and 1% a year for next 5 years. Maximum multiplier is 65%. Wages used to calculate benefit amounts will be the average over the 5 years the employee earned the most. IPERS uses a control year outside the “high 5” to test for wage spiking. For details regarding income options which may change your benefits, contact IPERS (see contact information on page 82).</td>
<td>Benefit amounts are based on: - the retirement income option you select - your age at the time benefits begin - the size of your retirement plan accumulations - the account’s rate of return before and after retirement</td>
</tr>
<tr>
<td>Plan Comparisons</td>
<td>IPERS</td>
<td>TIAA-CREF and VALIC</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Retirement Age</strong></td>
<td>Normal Retirement Age</td>
<td>You can withdraw funds without penalties:</td>
</tr>
<tr>
<td></td>
<td>• Age 65</td>
<td>• after you have retired from the University or</td>
</tr>
<tr>
<td></td>
<td>• Age 62 if you have 20 or more years of covered employment (62/20)</td>
<td>• upon reaching age 59 ½ if you separated from service before retirement.</td>
</tr>
<tr>
<td></td>
<td>• When your years of service plus your age equals or exceeds 88 (Rule of 88)</td>
<td></td>
</tr>
<tr>
<td>Early retirement, same as above plus reduction: The amount lifetime monthly benefits are reduced for early retirement increases to 6 percent times the number of years the member receives benefits before age 65. The 6 percent reduction for early retirement will affect only people who retire before reaching normal retirement age.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 70 or older, you may receive IPERS income and continue active ISU employment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Employee Contribution</strong></td>
<td>Currently: 5.78% of budgeted salary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>July 1, 2013: IPERS may adjust rate up or down by no more than 1.0 percentage point.</td>
<td>Year 1-5: 3.33% of first $4,800 of budgeted salary 5.00% of budgeted salary over $4,800</td>
</tr>
<tr>
<td></td>
<td>July 1, 2013: 5.95%</td>
<td>Year 6: 5.00% of budgeted Salary</td>
</tr>
<tr>
<td><strong>Maximum/Limit</strong></td>
<td>The calendar year wage ceiling is $255,000 (2013)</td>
<td>Annual Compensation limit is $255,000 (2013).</td>
</tr>
<tr>
<td></td>
<td>The IRS sets a maximum wage amount that can be covered by IPERS. Wages above this ceiling are not subject to IPERS withholding, and employers do not include them on IPERS reports. IPERS monitors covered wages for members with multiple employers. IPERS accepts all covered wages until a member has reached the IRS limit and will notify employers who report wages over the limit. IPERS will then return any excess contributions.</td>
<td>Annual Contribution limit that can be made to a participant’s account is $50,000, or 100% of your includible compensation for your most recent year of service. Generally, <em>includible compensation for your most recent year of service</em> is the amount of taxable wages and benefits you received from the employer that maintained a 403(b) account for your benefit during your most recent year of service.</td>
</tr>
<tr>
<td><strong>Employer Contribution</strong></td>
<td>Currently: 8.67% of budgeted salary</td>
<td>Year 1-5: 6.66% of first $4,800 of budgeted salary 10.00% of budgeted salary over $4,800</td>
</tr>
<tr>
<td></td>
<td>July 1, 2013: IPERS may adjust rate up or down by no more than 1.0 percentage point.</td>
<td>Year 6: 10.00% of budgeted Salary</td>
</tr>
<tr>
<td></td>
<td>July 1, 2013: 8.95%</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Plan Comparisons</th>
<th>IPERS</th>
<th>TIAA-CREF and VALIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contribution Example</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribution</td>
<td>$3,000.00 monthly budgeted salary</td>
<td>$3,000.00 monthly budgeted salary</td>
</tr>
<tr>
<td>Example</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td></td>
<td></td>
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<tr>
<td>$3,000.00</td>
<td></td>
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</tr>
<tr>
<td>5.78% of $3,000</td>
<td>$173.40</td>
<td>Employee contribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ISU contribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.67% of $3,000</td>
<td>$260.10</td>
<td>ISU contribution</td>
</tr>
<tr>
<td>Monthly Total</td>
<td>$433.50</td>
<td>Monthly Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$429.99</td>
</tr>
<tr>
<td><strong>Vesting</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Ownership in the retirement funds deposited in your account by ISU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your Contributions</td>
<td></td>
<td>Your Contributions</td>
</tr>
<tr>
<td>You are always 100 percent vested in your contributions.</td>
<td>You are always 100 percent vested in your contributions.</td>
<td></td>
</tr>
<tr>
<td>ISU Contributions</td>
<td></td>
<td>ISU Contributions</td>
</tr>
<tr>
<td>You are 100% vested after seven years of participation or attainment of age 55 while contributing.</td>
<td>If you were hired or your Letter of Intent was signed prior to July 1, 2009 you were immediately vested.</td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>A member not vested by July 1, 2012 will be vested after 7 years of participation or upon reaching 65 while in IPERS, whichever comes first to be 100% vested.</td>
<td>A member not vested by July 1, 2009 will become vested after 3 years of service. You will also become 100% vested when you reach age 65, if you become a disabled employee, if you die while employed or if ISU discontinues the retirement plan.</td>
<td></td>
</tr>
<tr>
<td><strong>Resign from ISU Employment</strong></td>
<td></td>
<td>Only your funds and vested ISU Contribution account balances are portable.</td>
</tr>
<tr>
<td>If you continue working in an IPERS - covered position (Iowa Public Employment), your participation under IPERS continues.</td>
<td>You may receive a lump sum payment once employment ends.</td>
<td></td>
</tr>
<tr>
<td>If you leave public employment, you may:</td>
<td></td>
<td>You may roll it over to another qualified plan or leave your money in TIAA-CREF/VALIC.</td>
</tr>
<tr>
<td>- roll the value of your account over to another qualified plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- take a refund</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- leave your funds on deposit with IPERS - non-vested: money will be in a non-interest bearing account. - vested: the funds will continue to accumulate interest.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Comparisons</td>
<td>IPERS</td>
<td>TIAA-CREF and VALIC</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>---------------------</td>
</tr>
<tr>
<td><strong>Re-employment</strong></td>
<td>Re-employment under the IPERS system within four years entitles you to a retirement income based on the old account. Interest on employee and ISU contributions resume with your rehire.</td>
<td>You will receive credit for full years of service you earned before your previous employment ended if your absence is not longer than five consecutive years.</td>
</tr>
</tbody>
</table>
| **Withdrawals and Loans** | IPERS does not allow you to borrow against your account, and only terminated members may withdraw money.  
Keep in mind that taking a withdrawal upon termination may not be in your best interest because you are forfeiting your membership rights. | ISU does not allow you to borrow against your retirement funds.  
Only terminated members may withdraw money, however, tax penalties may be accessed. |
| **Expenses** | The Iowa Legislature oversees IPERS’ expenses to ensure they are reasonable. Since a formula is used to calculate your benefit, what IPERS pays out in expenses does not affect the amount of your benefit.  
Counseling is free through IPERS. | Investment management fees vary by type of investments.  
The ISU University Benefits Committee monitors investment options and performance.  
Counseling is offered as a free service. |

**NOTE:** The initial election (or default) of IPERS, TIAA-CREF or VALIC is IRREVOCABLE. Even if you accept a different position at Iowa State University, where you would otherwise be eligible to choose any of the three programs, or if you terminate and become re-employed in another eligible position. The exceptions are for previous IPERS participation with another employer or while a student, post-doctoral, or casual hourly employee at ISU.
Tax Sheltered Annuities –
Group Supplemental Retirement Plans /
ROTH 403(b) Plans

Participation in a Tax Sheltered Annuity (TSA 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 amount from Iowa State 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 at: 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 account. Current contributions (salary reduction) to the plan are not taxable as income for Federal or State of Iowa income tax purposes. Investment returns on these accounts are also not currently taxable, but must remain in the system to compound.

Taxation:

Taxation on these accounts occurs whenever the money is received.

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) through TIAA-CREF or VALIC to participate.
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>After Age 59 ½</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 IRA’s</strong></td>
<td>Not permitted.</td>
<td>May be rolled over directly to a Roth IRA with no tax payment.</td>
</tr>
</tbody>
</table>
Genworth Financial, offers enrollment into the ISU group long term care product. The long term care will be an optional election.

Dates to Watch:

- January 22, 2013 through February 15, 2013 - initial enrollment for all eligible employees and their family members

- February (dates to be determined) there will be onsite meetings/webinars – dates available on Benefit Web Page

- Employees hired after February 15, 2013 have 30 days to apply for coverage without answering health questions. To apply before underwriting is required, go to the web link below https://longtermcare.genworth.com/fiveseries/login.do and use group ID: ISU and Access Code: groupltc.

Call 800-416-3624 if you have any questions about the coverage or enrolling once you open the webpage.
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](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.
  - For more information on vision discount services go to above link and click on “Vision Discount”

**Additional Benefits with Medical 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](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](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. See web address on page 82.

The following are available when enrolled in ISU basic life

- **Travel Assistance**

  As an employee covered by a group term life insurance policy form Principal Life Insurance Company, you are eligible for travel assistant services provided by AXA Assistance.

  You, your spouse and dependent children (whether traveling together or separately) have access to travel, medical, legal and financial assistance plus emergency medical evacuation benefits when traveling domestically or internationally 100 or more miles away from home for up to 120 consecutive day.

  These services are available 24 hours a day, 365 days a year.

  For more information call:
  - Within the U.S. 888-647-2611
  - Outside the U.S. call collect 630-766-7696

- **Identity Theft Kit & Will Preparation Services & more**

This is a big expense saver for families and a great value-added benefit!

As an option, if you are a covered employee under the group term life policy provided by Iowa State University.
Services are available through ARAG/Principal Financial Group. At any time you may begin using these free documents by visiting: www.ARAGwills.com/Principal.

- Will
- Living Will
- Healthcare Power of Attorney
- Financial Power of Attorney preparation

ARAG provides you with the information on how to protect and restore your identify if it is stolen.

To begin this service from the ARAG web site, click on:

- “Register Here” on the right-hand column of the screen.
- The system will require you to enter the Iowa State University group policy number is N1460 with Principal Financial Group.

If you have questions or would like to learn more about this service contact Customer Care at:

- 800-546-3718
- www.ARAGwills.com/Principal.

The following are available when enrolled in ISU life and/or long-term disability

- **Hearing Aid Program** – Free annual screenings through American Hearing Benefits, Inc. Eligible for up to 60% off digital hearing aids with two-ear warranty at no additional charge. For information go to: www.americanhearingbenefits.com or 866-925-128.

- **Weight Loss** - $10 off a three-month subscription to Weight Watchers Online. For information go to: www.principal.com/weightwatchers.

- **Oral Health Care** – Discounts available on Epic brand (contains Xylitol) toothpaste, oral rinse, mints and gum. 50% off the first order and 25% off reorders. For information go to: www.epicdental.com.

- **Magazine Program** – One year subscription to Diabetic Living for $6. Savings of 70% off regular retail price. For information to go: www.principal.com/diabeticliving.
Employee 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; or
- For a serious health condition that makes the employee unable to perform the employee’s job.

**Military family leave entitlements:**
Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation 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 a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

**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, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

**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 day 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.

State Workers’ Compensation:
ISU employees are automatically covered for this benefit. 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:**

Vacation is accumulated on a monthly basis. Part-time employees accumulate amounts equivalent to their fractional appointments. Vacation may accumulate to twice the annual entitlement.

- 1st through 4th year of employment: 10 days per year
- 5th through 11th year of employment: 15 days per year
- 12th through 19th year of employment: 20 days per year
- 20th through 24th year of employment: 22 days per year
- 25th and subsequent years of employment: 25 days per year

**Sick Leave:**

Full-time employees accrue sick leave at the rate of 12 hours per month with unlimited accumulation. Part-time employees accrue amounts equivalent to their fractional appointments.

After the accrual of 240 hours of sick leave, an employee may be eligible to elect to substitute 4 hours of vacation accrual for every 12 hours of sick leave. Conversion can occur only if no sick leave was used for that month and as long as the total accumulation remains above 240 hours. Converted sick leave may accumulate up to 96 hours.

**Holidays:**

The following are University holidays with pay:

- New Year’s 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:** University employees 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.

**Payroll and Benefit Information on AccessPlus:**

You will be able to see your earnings statement, found on the AccessPlus Web page (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 and 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.**
Initial COBRA Notification

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 medical, dental, vision, prescription, medical 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 the Qualifying Event).
H. A child 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 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 medical, 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 medical, dental and vision) you must, in this case, elect or decline COBRA coverage 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.

Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee’s Plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact Iowa State University for additional information. YOU MUST CONTACT IOWA STATE UNIVERSITY PROMPTLY AFTER QUALIFYING FOR THE HEALTH COVERAGE TAX CREDIT OR YOU WILL LOSE YOUR SPECIAL COBRA RIGHTS.

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 up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. If you have questions regarding continuation coverage or payments, please feel free to call the 800 number listed on your ID card. Payment(s) made at the time of election should be submitted and mailed with the Election Form.

Medical and Dental: It is important to note that, if you have chosen 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 the insurance carriers billing period.

After the initial premium, your monthly premium payment is due on the first day of each month for that month’s COBRA coverage. (medical and dental: for automatic account withdrawal, Wellmark allows a 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 payment is not submitted (medical and dental) or cannot be pulled from the designated account for automatic account withdrawal) for any reason, it is your responsibility to ensure that payment is remitted by the end of the grace period for the month for which premium 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 canceled retroactively to the first of the month.

Medical and Dental: If you have chosen automatic account withdrawal, premiums will be withdrawn from your designated checking or savings account on the designated day (1st or 5th) of each month. If submitting payments, your subsequent payments beyond those payment(s) submitted with the Election Form, should be submitted with your member identification number to the insurance carrier.

Vision: subsequent payments, beyond those payment(s) submitted with the Election Form, should be submitted with your member identification number to Benefits Office, 3810 Beardshear Hall, Ames, IA 50011-2033

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 during the disability extension period.
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.

Health Coverage Tax Credit: The Trade Act of 2002 created a new coverage tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new Trade Act provisions, eligible individuals can either take a tax credit or get advance payment (a portion of premiums paid for qualified health insurance, including continuation coverage). If you have questions about these new tax provisions, including details on the premium credit or payment amount eligible to qualifying beneficiaries for continuous coverage, you may call the Health Care Tax Credit Customer Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

V. COBRA Provisions.
A. Any qualified person may elect coverage for a dependent (Spouse, newborn child, adopted child, etc.) acquired during a period of continuation. Qualified persons must apply to the insurance carrier for coverage of acquired dependents within the same limits that pertain to enrollment of like dependents acquired by active employees. Please refer to your Benefit Booklet for provisions regarding dependent eligibility and effective dates. 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 by another group health Plan that does not contain an exclusion or limitation with respect to any pre-existing condition of the beneficiary other than an exclusion or limitation which does not apply or has been satisfied under HIPAA. COBRA coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the Qualified Beneficiary who becomes covered by another group health plan, and includes all COBRA coverages, such as dental, etc.;
   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 the insurance carrier individual plans and the individual carrier 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 the insurance carrier. The insurance carrier will provide outlines of coverage and copies of the individual plans and conversion plans upon request.
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 Department of Human Resource Services, 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.

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 800 number listed on your ID card.

Revised 02/2013
NOTICE OF PRIVACY PRACTICES
FOR
IOWA STATE UNIVERSITY BENEFITS OFFICE

THIS NOTICE DESCRIBES HOW MEDICAL 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

1. 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”.

2. 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 Medical 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.

3. Our Pledge Regarding Your Medical Information
We understand that medical 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, medical 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 medical information that identifies you is kept private.
- Provide you this notice of our legal duties and privacy practices regarding your medical 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.

4. How We May Use And Disclose Medical Information About You
The following categories describe ways that we use and disclose medical 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 medical 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 medical 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 medical 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 medical reimbursement flexible spending account and the like.
- **For Treatment:** We may disclose your medical information to a doctor or a hospital which asks us for it to assist in your treatment. We may share 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.

5. 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 medical 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 medical information for any reason except those described in this notice.

6. Exception to General Rule For Uses and Disclosures To Family or Friends Involved in Your Health care
Before we disclose your medical 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, medical supplies, x-rays, or other forms of medical information. In these situations, only the minimum necessary PHI that is relevant to your health care will be disclosed.
7. 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 medical reimbursement flexible spending account program to ISU or other organization that sponsors your group health plan, administers the medical 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 medical 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 medical 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 medical 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 medical information will only be as described in this notice.

7.3 For Marketing: We may use your medical 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 medical 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 medical information of a deceased person to a coroner, medical 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 medical 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 medical 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. We will not be bound unless our agreement is so memorialized in writing.

8.3 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 you 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.

8.4 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 medical information or in response to a request you made to amend or restrict the use or disclosure of your medical 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 medical 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
Human Resources Service Center,
3810 Beardshear
Telephone: 515-294-4800 / 877-477-7485
Fax: 515-294-4707 and E-mail: benefits@iastate.edu
Understanding Benefit Language

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 Medical section of the Benefits web page:  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 Iowa Select plan’s in-network coverage is 90% and your share (coinsurance 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 State of Iowa 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 Plan, 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 Blue Cross or Blue Shield the State of Iowa Managed Care Plans 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, in the option of a physician with knowledge of the member’s medical 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.
# Web Access Information

The following is a list of web sites and telephone numbers associated with your benefits:

| Human Resources Service Center | 515-294-4800 / 877-477-7485 | 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 to the “Non-Supervisory Merit” line for each benefit category. |
| --- | --- | --- |
Human Resources Customer Service – CustServe.HRE@iowa.gov |

## MEDICAL PLANS

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

Web/phone to find/call for participating Physician Information.

Wellmark BC/BS of Iowa – Iowa or National site for Nationwide search for providers.

- 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”

<table>
<thead>
<tr>
<th>Classic Blue Plan</th>
<th>Program 3 Plus</th>
<th>800-622-0043</th>
<th><a href="http://www.wellmark.com">www.wellmark.com</a></th>
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<tbody>
<tr>
<td>Alliance Select (PPO)</td>
<td>Iowa Select</td>
<td>800-622-0043</td>
<td><a href="http://www.wellmark.com">www.wellmark.com</a></td>
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Wellmark Health Plan of Iowa (WHIPI) - Iowa site for local, in-state providers

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<tr>
<th>Primary Care Plan</th>
<th>Blue Advantage</th>
<th>800-553-7801</th>
<th><a href="http://www.wellmark.com">www.wellmark.com</a></th>
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<tbody>
<tr>
<td>Open Access Plan</td>
<td>Blue Access</td>
<td>800-553-7801</td>
<td><a href="http://www.wellmark.com">www.wellmark.com</a></td>
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## Summary of Benefits & Coverage

Printed copies are available by request

### Traditional Premium Contribution Plans


### Voluntary Premium Contributions Plans

### DENTAL PLAN

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

<table>
<thead>
<tr>
<th>Delta Dental of Iowa</th>
<th>800-544-0718</th>
<th><a href="http://www.deltadentalia.com">www.deltadentalia.com</a></th>
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<tr>
<td></td>
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<td>Call or access Delta website for a participating dentist directory. Search under the Delta Dental Premier Plan.</td>
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<td>Delta Dental also includes a vision discount program through EyeMed click on:</td>
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<td>- Member Tab</td>
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<td>- Then Vision Discount</td>
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### HEALTH CARE FLEXIBLE SPENDING ACCOUNT and DEPENDENT CARE ASSISTANCE PROGRAM

800-659-3035 | [www.myASIFlexonline.com](http://www.myASIFlexonline.com) – for individual account information

### RETIREMENT PLANS

**IPERS** - [www.ipers.org](http://www.ipers.org) or call 800-622-3849

**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** – daniel.allen@valic.com – 913-402-5000 (District) or 515-770-1725 (Cellular)

### EYEWEAR PLAN


### LONG TERM CARE INSURANCE


### EMPLOYEE ASSISTANT 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

**PERKSPOT**


**WELLMARK – BLUE 365**


#### Principal Financial Group

Available When Enrolled in Basic Life

**WILL PREPARATION**

ARAG/Principal 800-546-3718 | Use Anytime [www.ARGwills.com/Principal](http://www.ARGwills.com/Principal)

ISU Group number - N1460

**AXA Assistance**

In U.S.-888-647-2611 Outside of U.S.-call collect 630-766-7696 | Travel Assistance

#### Principal Financial Group

Available When Enrolled in Basic Life and/or Long Term Disability

**Hearing Aid Program**

866-925-1287 | [www.americanhearingbenefits.com](http://www.americanhearingbenefits.com)

**Weight Loss**

[www.principal.com/weightwatchers](http://www.principal.com/weightwatchers)

**Oral Health Care**

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

**Diabetic Magazine Program**

[www.principal.com/diabeticliving](http://www.principal.com/diabeticliving)