

C O V E R A G E M A N U A L

BlueChoice[®]
Blue Rx Value PlusSM
Iowa State University SSHIP POS HMO
isu
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NOTICE

This group health plan is sponsored and funded by your group sponsor. Your group sponsor has a financial arrangement with Wellmark under which your group sponsor is solely responsible for claim payment amounts for covered services provided to you. Wellmark provides administrative services and provider network access only and does not assume any financial risk or obligation for claim payment amounts.

Contents

About This Coverage Manual	1
1. What You Pay.....	5
Payment Summary	5
Payment Details	7
2. At a Glance - Covered and Not Covered.....	15
Medical	15
Prescription Drugs.....	18
3. Details - Covered and Not Covered.....	19
Medical	19
Prescription Drugs.....	37
4. General Conditions of Coverage, Exclusions, and Limitations	41
Conditions of Coverage.....	41
General Exclusions	42
Benefit Limitations	44
5. Choosing a Provider	47
Medical	47
Prescription Drugs.....	54
6. Notification Requirements and Care Coordination	57
Medical	57
Prescription Drugs.....	61
7. Factors Affecting What You Pay.....	63
Medical	63
Prescription Drugs.....	67
8. Coverage Eligibility and Effective Date	71
Eligible Members	71
When Coverage Begins	71
Changes to Information Related to You or to Your Benefits	71
Qualified Medical Child Support Order	72
9. Coverage Changes and Termination	73
Coverage Change Events	73
Requirement to Notify Group Sponsor.....	74
Coverage Termination.....	74
Coverage Continuation.....	75
10. Claims	77
When to File a Claim	77
How to File a Claim.....	77
Notification of Decision.....	78
11. Coordination of Benefits	81
Other Coverage.....	81
Claim Filing	81
Rules of Coordination.....	82
Coordination with Medicare	84

12.	Appeals.....	87
	Right of Appeal.....	87
	How to Request an Internal Appeal.....	87
	Where to Send Internal Appeal.....	87
	Review of Internal Appeal.....	87
	Decision on Internal Appeal.....	88
	External Review.....	88
	Arbitration and Legal Action.....	89
13.	Arbitration and Legal Action.....	91
	Mandatory Arbitration.....	91
	Covered Claims.....	91
	No Class Arbitrations and Class Actions Waiver.....	91
	Claims Excluded from Mandatory Arbitration.....	91
	Arbitration Process Generally.....	92
	Arbitration Fees and Other Costs.....	93
	Confidentiality.....	93
	Questions of Arbitrability.....	93
	Claims Excluded By Applicable Law.....	93
	Survival and Severability of Terms.....	93
14.	General Provisions.....	95
	Contract.....	95
	Interpreting this Coverage Manual.....	95
	Plan Year.....	95
	Authority to Terminate, Amend, or Modify.....	95
	Authorized Group Benefits Plan Changes.....	95
	Member Participation.....	95
	Authorized Representative.....	95
	Release of Information.....	96
	Privacy of Information.....	96
	Member Health Support Services.....	97
	Value Added or Innovative Benefits.....	97
	Value-Based Programs.....	97
	Nonassignment.....	97
	Governing Law.....	97
	Medicaid Enrollment and Payments to Medicaid.....	98
	Subrogation.....	98
	Workers' Compensation.....	100
	Payment in Error.....	100
	Notice.....	101
	Inspection of Coverage.....	101
	Submitting a Complaint.....	101
	Consent to Telephone Calls and Text or Email Notifications.....	101
	Glossary.....	103
	Index.....	107

About This Coverage Manual

Contract

This coverage manual describes your rights and responsibilities under your group health plan. You and your covered dependents have the right to request a copy of this coverage manual, at no cost to you, by contacting your group sponsor.

Please note: Your group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage manual at any time. Any amendment or modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

You should familiarize yourself with the entire manual because it describes your benefits, payment obligations, provider networks, claim processes, and other rights and responsibilities.

This group health plan consists of medical benefits and prescription drug benefits. Your Wellmark Health Plan of Iowa, Inc., (Wellmark) point-of-service (POS) benefits are called Blue Choice. The prescription drug benefits are called Blue Rx Value Plus. This coverage manual will indicate when the service, supply or drug is considered medical benefits or drug benefits by using sections, headings, and notes when necessary.

Charts

Some sections have charts, which provide a quick reference or summary but are not a complete description of all details about a topic. A particular chart may not describe some significant factors that would help determine your coverage, payments, or other responsibilities. It is important for you to look up details and not to rely only upon a chart. It is also important to follow any references to other parts of the manual. (References tell you to “see” a section or subject heading, such as, “See *Details – Covered and Not Covered*.” References may also include a page number.)

Complete Information

Very often, complete information on a subject requires you to consult more than one section of the manual. For instance, most information on coverage will be found in these sections:

- At a Glance – Covered and Not Covered
- Details – Covered and Not Covered
- General Conditions of Coverage, Exclusions, and Limitations

However, coverage might be affected also by your choice of provider (information in the *Choosing a Provider* section), certain notification requirements if applicable to your group health plan (the *Notification Requirements and Care Coordination* section), and considerations of eligibility (the *Coverage Eligibility and Effective Date* section).

Even if a service is listed as covered, benefits might not be available in certain situations, and even if a service is not specifically described as being excluded, it might not be covered.

Read Thoroughly

You can use your group health plan to the best advantage by learning how this document is organized and how sections are related to each other. And whenever you look up a particular topic, follow any references, and read thoroughly.

Your coverage includes many services, treatments, supplies, devices, and drugs. Throughout the coverage manual, the words *services or supplies* refer to any services, treatments, supplies, devices, or drugs, as applicable in the context, that may be used to diagnose or treat a condition.

Questions

If you have questions about your group health plan, or are unsure whether a particular service or supply is covered, call the Customer Service number on your ID card.

Plan Description

Plan Name:	Iowa State University Student Scholar Health Insurance Plan
Plan Sponsor:	Iowa State University of Science and Technology
Group Sponsor ID Number:	42-6004224
When Plan Year Ends:	July 31
Participants of Plan:	The following must enroll in SSHIP or have an approved waiver on file: <ul style="list-style-type: none">• International students enrolled for at least one credit hour (except those enrolled exclusively in audit courses). Automatic Enrollment in a self-only plan.• International and Domestic graduate assistants with a paid assistantship. Automatic enrollment in a self-only plan.• International Visiting scholars and their dependents. Mandatory ISU coverage and cannot be waived unless coverage is also provided as an ISU employee.• Domestic undergraduate/graduate students without assistantships enrolled for at least five credit hours.
Plan Administrator and Agent for Service of Legal Process:	Iowa State University of Science and Technology Division of Finance 1350 Beardshear Hall Ames, IA 50111-2103 Phone Number: 515-294-6162
How Plan Costs Are Funded:	All domestic and international Undergraduate/graduate students premiums will be applied to the Students University Bill (U-Bill). Visiting Scholars premiums that are not covered by their hosting ISU department will be billed to the Scholars University Bill (U-bill). Graduate Assistants selecting any coverage tiers besides Single, the Student is required to contribute toward the cost of yourself and spouse/domestic partner, yourself and children, or yourself and family coverage. This contribution will be collected through their monthly paycheck.
Type of Plan:	Group Health Plan
Type of Administration:	Self-Funded
Benefits Administered by:	Wellmark Health Plan of Iowa, Inc. 1331 Grand Avenue Des Moines, IA 50309-2901

1. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire coverage manual, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Provider Network

Under the medical benefits of this plan, your network of providers consists of domestic providers, Wellmark Blue POSSM and Participating providers. All other providers are not in your network. Which provider type you choose will affect what you pay.

Benefit Levels

Your Blue Choice medical program is unique because you have the flexibility to go to almost any provider you choose. However, how you access care affects what you pay.

Benefit Level 1 in general applies when you receive services from a domestic provider. Domestic providers participate directly with your employer's domestic provider network and also participate with the Wellmark Blue POS network. These are Network Providers who participate with ISU Thielen Student Health Center.

Benefit Level 2 in general applies when you receive services from a Network Provider. Network Providers participate with the Wellmark Blue POS network, but not with your employer's domestic provider network.

Benefit Level 3 in general applies when you receive services from an Out-of-Network Provider and services are not coordinated by a domestic or Wellmark Blue POS provider. Out-of-Network Providers do not participate with the Wellmark Blue POS network or your employer's domestic provider network.

Payment Summary

This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

Medical

You Pay

Deductible

Benefit Level 1 (Domestic Providers)

\$0 per person

\$0 (maximum) per family*

Benefit Level 2 (Network Providers)

\$450 per person

\$900 (maximum) per family*

Benefit Level 3 (Out-of-Network Providers)

\$600 per person

\$1,200 (maximum) per family*

Emergency Room Copayment

\$100

You Pay

Other Copayment

Benefit Level 1 (Domestic Providers)

\$10 for covered physical therapy.

Benefit Level 2 (Network Providers)

\$10 for covered office and outpatient chiropract care, occupational, and physical therapy.

Outpatient Copayment

Benefit Level 1 (Domestic Providers)

\$100 for covered home/durable medical equipment.

Coinsurance

Benefit Level 1 (Domestic Providers)

0%

Benefit Level 2 (Network Providers) and for covered ambulance services

20%

Benefit Level 3 (Out-of-Network Providers)

40%

Out-of-Pocket Maximum

\$4,100 per person. This includes amounts you pay for covered drugs.

\$8,200 (maximum) per family.** This includes amounts you pay for covered drugs.

*Each family member must contribute to their own individual deductible until the total amount of deductible expenses accumulated by all family members meets the maximum family deductible.

**Each family member must contribute to their own individual out-of-pocket maximum until the total amount of out-of-pocket expenses accumulated by all family members meets the family out-of-pocket maximum amount.

Please note: Out-of-pocket maximum amounts you pay for covered medical benefits under Blue Choice also apply toward the Blue Rx Value Plus out-of-pocket maximum. Likewise, out-of-pocket maximum amounts you pay for covered prescription drug benefits under Blue Rx Value Plus apply toward the Blue Choice medical out-of-pocket maximum.

Prescription Drugs

You Pay†

Coinsurance or Copayment

\$10 for Tier 1 medications.

\$20 for Tier 2 and 3 medications.

For more information see *Tiers*, page 68.

\$100 home/durable medical equipment received from Thielen Student Health Center.

20% for pharmacy durable medical equipment devices received from participating pharmacies.

40% for pharmacy durable medical equipment devices received from nonparticipating pharmacies.

Out-of-Pocket Maximum

\$4,100 per person

\$8,200 (maximum) per family*

*Each family member must contribute to their own individual out-of-pocket maximum until the total amount of out-of-pocket expenses accumulated by all family members meets the family out-of-pocket maximum amount.

†You pay the entire cost if you purchase a drug or pharmacy durable medical equipment device that is not on the Wellmark Blue Rx Value Plus Drug List. See *Wellmark Blue Rx Value Plus Drug List*, page 38.

Please note: Out-of-pocket maximum amounts you pay for covered prescription drug benefits under Blue Rx Value Plus apply toward the Blue Choice medical out-of-pocket maximum. Likewise, out-of-pocket maximum amounts you pay for covered medical benefits under Blue Choice also apply toward the Blue Rx Value Plus out-of-pocket maximum.

Prescription Maximums

Generally, there is a maximum days' supply of medication you may receive in a single prescription. However, exceptions may be made for certain prescriptions packaged in a dose exceeding the maximum days' supply covered under your Blue Rx Value Plus prescription drug benefits. To determine if this exception applies to your prescription, call the Customer Service number on your ID card.

Your payment obligations may be determined by the quantity of medication you purchase.

Payment
90 day retail
Payment per days' supply:
1 copayment for 30 day supply
2 copayments for 60 day supply
3 copayments for 90 day supply
30 day specialty
1 copayment

Payment Details

Medical

Deductible

This is a fixed dollar amount you pay for covered services in a benefit year before medical benefits become available.

The family deductible amount is reached from amounts accumulated on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

Deductible amounts you pay for covered services received at Benefit Level 1 and 2 or at Benefit Level 3 apply toward meeting both the Benefit Level 1 and 2 deductible and the Benefit Level 3 deductible. The maximum deductible amount you pay is the Benefit Level 3 deductible.

Once you meet the deductible, then coinsurance applies.

When the No Surprises Act applies, you may not be required to satisfy your entire deductible before we make benefit payments, amounts you pay for items and services will accumulate toward your Wellmark Blue POS deductible, and you may not be billed for more than the amount you would pay if the services had been

provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Deductible amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Copayment

This is a fixed dollar amount that you pay each time you receive certain covered services.

Emergency Room Copayment.

The emergency room copayment:

- applies to emergency room services.
- is taken once per visit.
- is waived if you are admitted as an inpatient of a facility immediately following emergency room services.

Other Copayment.

The other copayment:

- applies to physical therapy received from a domestic or Wellmark Blue POS provider and office and outpatient chiropractic care and occupational therapy received from a Wellmark Blue POS Provider.
- is taken once per date of service.

Outpatient Copayment.

The outpatient copayment:

- applies to home/durable medical equipment received from a domestic provider.
- is taken once per date of service.

Copayment amount(s) are waived for some services. See *Waived Payment Obligations* later in this section.

Coinsurance

Coinsurance is an amount you pay for certain covered services. Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance is Calculated*, page 63. Coinsurance amounts apply after you meet the deductible.

Coinsurance amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum amount you pay, out of your pocket, for most covered services in a benefit year. Many amounts you pay for covered services during a benefit year accumulate toward the out-of-pocket maximum according to applicable provider network cost sharing. These amounts include:

- Deductible.

- Coinsurance.
- Emergency room copayments.
- Other copayments.
- Outpatient copayments.
- Amounts you pay for covered prescription drugs.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single out-of-pocket maximum.

Out-of-pocket maximum amounts you pay for covered medical benefits under Blue Choice also apply toward the Blue Rx Value Plus out-of-pocket maximum. Likewise, out-of-pocket maximum amounts you pay for covered prescription drug benefits under Blue Rx Value Plus apply toward the Blue Choice medical out-of-pocket maximum.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

These amounts continue even after you have met your out-of-pocket maximum.

When the No Surprises Act applies, amounts you pay for items and services will accumulate toward your Wellmark Blue POS out-of-pocket maximum and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency

services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Benefits Maximums

Benefits maximums are the maximum benefit amounts that each member is eligible to receive.

Benefits maximums that apply per benefit year or per lifetime are reached from benefits accumulated under this group health plan and any prior group health plans sponsored by your group sponsor and administered by Wellmark Health Plan of Iowa, Inc.

Benefits maximums accumulate from benefits provided at Benefit Level 1, 2, or 3 combined.

No Surprises Act

When the No Surprises Act applies, the amount you pay will be determined in accordance with the Act and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Waived Payment Obligations

To understand your complete payment obligations you must become familiar with this entire coverage manual. Most information on coverage and benefits maximums will be found in the *At a Glance – Covered and Not Covered* and *Details – Covered and Not Covered* sections.

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Ambulance services for treatment of mental health conditions and chemical dependency received at Benefit Level 2.	Deductible Coinsurance
Breast pumps (manual or non-hospital grade electric) purchased from a covered Wellmark Blue POS or Participating home/durable medical equipment provider.	Deductible Coinsurance
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding when received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance
Chiropractic care and occupational therapy for treatment of mental health conditions and chemical dependency – office and outpatient services received from Wellmark Blue POS Providers.	Deductible Coinsurance Copayment
Contraceptive medical devices, such as intrauterine devices and diaphragms received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance
Home health services for treatment of mental health conditions and chemical dependency received at Benefit Level 2.	Deductible Coinsurance

Covered Service	Payment Obligation Waived
Home/durable medical equipment for treatment of mental health and chemical dependency received from domestic providers.	Copayment
Implanted and injected contraceptives received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance
Independent laboratory services for treatment of mental health conditions and chemical dependency received at Benefit Level 2.	Deductible Coinsurance
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines when received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance
Mental health conditions and chemical dependency treatment – office and urgent care services received at Benefit Level 2.	Deductible Coinsurance
Mental health conditions and chemical dependency treatment – outpatient services received at Benefit Level 2.	Deductible Coinsurance
Newborn’s initial hospitalization, when considered normal newborn care – facility services received at any level and practitioner services. Please note: When these services are received at Benefit Level 2, coinsurance is also waived.	Deductible Coinsurance
Physical therapy received from domestic or Wellmark Blue POS providers for treatment of mental health conditions and chemical dependency.	Deductible Coinsurance Copayment
Preventive care, items, and services,* received from Wellmark Blue POS or Participating providers, as follows: <ul style="list-style-type: none"> ■ Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP); ■ Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and ■ Preventive care and screenings for women provided for in guidelines supported by the HRSA. Please note: When well-child care is received at Benefit Level 3, only deductible is waived.	Deductible Coinsurance
Preventive digital breast tomosynthesis (3D mammogram) when received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance

Covered Service	Payment Obligation Waived
Prosthetic limb devices received at Benefit Level 2.	Deductible
Services subject to emergency room copayment amounts.	Deductible Coinsurance
Services subject to other copayment amounts.	Deductible Coinsurance
Telehealth mental health conditions and chemical dependency services received at Benefit Level 2.	Deductible Coinsurance
Vision examination (routine) received at Benefit Level 2.	Deductible Coinsurance
Voluntary sterilization for female members received from Wellmark Blue POS or Participating providers.	Deductible Coinsurance

*A complete list of recommendations and guidelines related to preventive services can be found at www.healthcare.gov. Recommended preventive services are subject to change and are subject to medical management. USPSTF “A” and “B” recommendations will be implemented no later than the first plan year that begins on or after the date that is one year after the USPSTF recommendations are issued. A USPSTF recommendation is considered to be issued on the last day of the month on which it publishes or otherwise releases the recommendation. Waived Payment Obligations will be effective following implementation of the USPSTF recommendation.

Prescription Drugs

Copayment

Copayment is a fixed dollar amount you pay each time certain covered prescriptions subject to copayment are filled or refilled.

Coinsurance

Coinsurance is the amount you pay, calculated using a fixed percentage of the maximum allowable fee, each time certain covered prescriptions subject to coinsurance are filled or refilled.

You pay the entire cost if you purchase a drug or pharmacy durable medical equipment device that is not on the Wellmark Blue Rx Value Plus Drug List. See *Wellmark Blue Rx Value Plus Drug List*, page 38.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum you pay in a given benefit year toward the following amounts:

- Coinsurance.
- Copayments.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single out-of-pocket maximum.

Out-of-pocket maximum amounts you pay for covered prescription drug benefits under Blue Rx Value Plus also apply toward the Blue Choice medical out-of-pocket maximum. Likewise, out-of-pocket maximum amounts you pay for covered

medical benefits under Blue Choice apply toward the Blue Rx Value Plus out-of-pocket maximum.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.

- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved “A”-rated medically appropriate generic equivalent.

These amounts continue even after you have met your out-of-pocket maximum.

Waived Payment Obligations

To understand your complete payment obligations you must become familiar with this entire coverage manual. Most information on coverage and benefits maximums will be found in the *Details – Covered and Not Covered* section.

Some payment obligations are waived for the following covered drugs or services.

Covered Drug or Service	Payment Obligation Waived
<p>Generic contraceptive drugs and generic contraceptive drug delivery devices (e.g., birth control patches).</p> <p>Payment obligations are also waived if you purchase brand name contraceptive drugs or brand name drug delivery devices when an FDA-approved medically appropriate generic equivalent is not available.</p> <p>Payment obligations are not waived if you purchase brand name contraceptive drugs or brand name contraceptive drug delivery devices when an FDA-approved medically appropriate generic equivalent is available.</p>	<p>Copayment</p>
<p>Preventive items or services* as follows:</p> <ul style="list-style-type: none"> ■ Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); and ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP). 	<p>Copayment</p>
<p>Two smoking cessation attempts per calendar year, up to a 90-days' supply of covered drugs for each attempt, or a 180-days' supply total per calendar year.</p>	<p>Copayment</p>

*A complete list of recommendations and guidelines related to preventive services can be found at www.healthcare.gov. Recommended preventive items and services are subject to change and are subject to medical management. USPSTF “A” and “B” recommendations will be implemented no later than the first plan year that begins on or after the date that is one year after the USPSTF recommendations are issued. A USPSTF recommendation is considered to be issued on the last day of the month on which it publishes or otherwise releases the

recommendation. Waived Payment Obligations will be effective following implementation of the USPSTF recommendation.

2. At a Glance - Covered and Not Covered

Medical

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this coverage manual. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 19. To fully understand which services are covered and which are not, you must become familiar with this entire coverage manual. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

Category. Service categories are listed alphabetically and are repeated, with additional detailed information, in *Details – Covered and Not Covered*.

Covered. The listed category is generally covered, but some restrictions may apply.

Not Covered. The listed category is generally not covered.

See Page. This column lists the page number in *Details – Covered and Not Covered* where there is further information about the category.

Benefits Maximums. This column lists maximum benefit amounts that each member is eligible to receive. Benefits maximums that apply per benefit year or per lifetime are reached from benefits accumulated under this group health plan and any prior group health plans sponsored by your group sponsor and administered by Wellmark Health Plan of Iowa, Inc.

Category	Covered	Not Covered	See Page	Benefits Maximums
Acupuncture Treatment		⊖	19	
Allergy Testing and Treatment	●		19	
Ambulance Services	●		19	
Anesthesia	●		20	
Autism Treatment	●		20	
Blood and Blood Administration	●		20	
Chemical Dependency Treatment	●		20	
Chemotherapy and Radiation Therapy	●		21	
Clinical Trials – Routine Care Associated with Clinical Trials	●		21	
Contraceptives	●		21	
Conversion Therapy		⊖	21	
Cosmetic Services		⊖	22	

Category	Covered	Not Covered	See Page	Benefits Maximums
Counseling and Education Services	●		22	
Dental Treatment for Accidental Injury	●		22	
Dialysis	●		23	
Education Services for Diabetes and Nutrition	●		23	
Emergency Services	●		23	
Fertility and Infertility Services	●		24	
Genetic Testing	●		24	
Hearing Services	●		24	
Home Health Services	●		24	The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		25	
Hospice Services	●		26	15 days per lifetime for inpatient hospice respite care. 15 days per lifetime for outpatient hospice respite care. Please note: Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		26	90 days per benefit year of skilled nursing services in a hospital or nursing facility.
Illness or Injury Services	●		27	
Inhalation Therapy	●		27	
Maternity Services	●		27	
Medical and Surgical Supplies and Personal Convenience Items	●		28	
Medical Evacuation	●		29	
Mental Health Services	●		29	
Motor Vehicles		⊖	30	
Musculoskeletal Treatment	●		30	
Nonmedical or Administrative Services		⊖	30	
Nutritional and Dietary Supplements	●		30	
Occupational Therapy	●		31	
Orthotics (Foot)		⊖	31	
Physical Therapy	●		31	
Physicians and Practitioners			32	
Advanced Registered Nurse Practitioners	●		32	
Audiologists	●		32	
Chiropractors	●		32	
Doctors of Osteopathy	●		32	

Category	Covered	Not Covered	See Page	Benefits Maximums
Licensed Independent Social Workers	●		32	
Licensed Marriage and Family Therapists	●		32	
Licensed Mental Health Counselors	●		32	
Medical Doctors	●		32	
Occupational Therapists	●		32	
Optometrists	●		32	
Oral Surgeons	●		32	
Physical Therapists	●		32	
Physician Assistants	●		32	
Podiatrists	●		32	
Psychologists	●		32	
Speech Pathologists	●		32	
Prescription Drugs	●		32	
Preventive Care	●		33	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year. One routine Pap smear per benefit year.
Prosthetic Devices	●		34	
Reconstructive Surgery	●		35	
Repatriation	●		35	
Self-Help Programs		⊖	35	
Sleep Apnea Treatment	●		35	
Social Adjustment		⊖	35	
Speech Therapy	●		35	
Surgery	●		35	
Telehealth Services	●		36	
Temporomandibular Joint Disorder (TMD)	●		36	
Transplants	●		36	
Travel or Lodging Costs	●		37	\$10,000 per transplant.

Category	Covered	Not Covered	See Page	Benefits Maximums
Vision Services	●		37	One routine vision examination per benefit year.
Wigs or Hairpieces	●		37	
X-ray and Laboratory Services	●		37	

Prescription Drugs

Please note: To determine if a drug is covered, you must consult the Wellmark Blue Rx Value Plus Drug List. You are covered for drugs listed on the Wellmark Blue Rx Value Plus Drug List. If a drug is not on the Wellmark Blue Rx Value Plus Drug List, it is not covered.

For details on drug coverage, drug limitations, and drug exclusions, see the next section, *Details – Covered and Not Covered*.

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this coverage manual. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 41. If a service or supply is not specifically listed, do not assume it is covered.

Medical

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered:

- Emergency air and ground ambulance transportation to a hospital.
All of the following are required to qualify for benefits:
 - If you are inpatient, the services required to treat your illness or injury are not available where you are currently receiving care.
 - You are transported to the nearest hospital in the Wellmark Blue POS network with adequate facilities to treat your medical condition. In an emergency situation, you should seek care at the nearest appropriate hospital, whether the hospital is in-network or out-of-network.
 - During transport, your medical condition requires the services that are provided only by an air or ground ambulance.
 - Your medical condition requires immediate ambulance transport.
 - In addition to the preceding requirements, for emergency air ambulance services to be covered, the following must be met:

- Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment by ground transport.

When the No Surprises Act applies to air ambulance services, you cannot be billed for the difference between the amount charged and the total amount paid by us.

In an emergency situation, if you cannot reasonably utilize a domestic ambulance service, covered services will be reimbursed as though they were received from a domestic ambulance service. However, if ground ambulance services are provided by an Out-of-Network Provider, and because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you may be responsible for any difference between the amount charged and our amount paid for a covered service. When receiving ground ambulance services, select a provider who participates in your network to avoid being responsible for any difference between the billed charge and our settlement amount.

- Non-emergency air or ground ambulance transportation to a hospital or nursing facility.
All of the following are required to qualify for benefits:
 - The services required to treat your illness or injury are not available where you are currently receiving care.
 - You are transported to the nearest hospital or nursing facility with

adequate facilities to treat your medical condition.

- During transport your medical condition requires the services that are provided only by an air or ground ambulance.
- In addition to the preceding requirements, for non-emergency air ambulance services to be covered, all of the following must be met:
 - You must already be receiving care at a hospital.
 - Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital or nursing facility with appropriate facilities for treatment by ground transport.

Not Covered:

- Air or ground ambulance transport from a facility capable of treating your condition.
- Air or ground ambulance transport to or from any location when you are physically and mentally capable of being a passenger in a private vehicle.
- Round-trip transports from your residence to a medical provider for an appointment or treatment and back to your residence.
- Air or ground transport when performed primarily for your convenience or the convenience of your family, physician, or other health care provider, such as a transfer to a hospital or facility that is closer to your home or family.
- Non-ambulance transport to any location for any reason. This includes private vehicle transport, commercial air transport, police transport, taxi, public transportation such as train or bus, ride-share vehicles such as Uber or Lyft, and vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst. Applied Behavior Analysis services are also covered for treatment of conditions other than autism spectrum disorder.

Blood and Blood Administration

Covered: Blood and blood administration, including blood derivatives, and blood components.

Chemical Dependency Treatment

Covered: Treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs or alcohol as described in the most current *Diagnostic and Statistical Manual of Mental Disorders*.

Licensed Substance Abuse Treatment Program. Benefits are available for chemical dependency treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;

- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Treatment provided in a medically monitored intensive inpatient or detoxification setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in substance abuse treatment programs.

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 57.

Chemotherapy and Radiation Therapy

Covered: Use of chemical agents or radiation to treat or control a serious illness.

Clinical Trials – Routine Care Associated with Clinical Trials

Covered: Medically necessary routine patient costs for items and services otherwise covered under this plan furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when a covered

member is referred by a domestic or Wellmark Blue POS provider based on the conclusion that the member is eligible to participate in an approved clinical trial according to the trial protocol or the member provides medical and scientific information establishing that the member’s participation in the clinical trial would be appropriate according to the trial protocol.

Not Covered:

- Investigational or experimental items, devices, or services which are themselves the subject of the clinical trial;
- Clinical trials, items, and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Contraceptives

Covered: The following conception prevention, as approved by the U.S. Food and Drug Administration:

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.

Please note: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches are covered under your Blue Rx Value Plus prescription drug benefits described later in this section.

See the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com* or call the Customer Service number on your ID card and request a copy of the Drug List.

Conversion Therapy

Not Covered: Conversion therapy services.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. However, a service, supply, or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling and Education Services

Covered:

- Bereavement counseling or services.
- Family or marriage counseling or services.

Not Covered:

- Community-based services or services of volunteers or clergy.
- Education or educational therapy other than covered lactation consultant services, education for self-management of diabetes, or nutrition education.
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for weight reduction, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia, for any medical, mental health, or substance abuse condition.
- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes and Nutrition later in this section.

Mental Health Services later in this section.

Preventive Care later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when all of the following requirements are met:
 - Initial treatment is received within 12 months of the injury.
 - Follow-up treatment is completed within 24 months.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
 - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
 - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Orthodontic services associated with management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease of the

mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); or
- Treatment of neoplasms of the mouth and contiguous tissue.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or management of cleft palate.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes and Nutrition

Covered: Inpatient and outpatient training and education for the self-management of all types of diabetes mellitus.

All covered training or education must be prescribed by a licensed physician.

Outpatient training or education must be provided by a state-certified program.

The state-certified diabetic education program helps any type of diabetic and his

or her family understand the diabetes disease process and the daily management of diabetes.

You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your nutritional requirements. Nutrition education is appropriate for the following conditions:

- Cancer.
- Cystic fibrosis.
- Diabetes.
- Eating disorders.
- Glucose intolerance.
- High blood pressure.
- High cholesterol.
- Lactose intolerance.
- Malabsorption, including gluten intolerance.
- Obesity.
- Underweight.

Emergency Services

Covered: When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a domestic provider, covered services will be reimbursed as though they were received from a domestic provider. When the No Surprises Act applies to emergency services, you cannot be billed for the difference between the amount charged and the total amount paid by us. If

you receive medically necessary emergency services to treat an emergency medical condition, those services will be covered as required under the No Surprises Act notwithstanding any other plan exclusion.

See Also:

Out-of-Network Providers, page 64.

Fertility and Infertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
- Fertility and infertility services until you receive artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure.

Not Covered:

- Services and supplies associated with infertility treatment if the infertility is the result of voluntary sterilization.
- The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures or for any other reason or service; freezing and storage of sperm, oocytes, or embryos; surrogate parent services.
- Artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure. If you have any of these procedures done, benefits for all types of fertility or infertility treatment (including drug induced stimulation of ovulation) will end beginning on the day you receive the noncovered service and you will then be no longer eligible for any fertility or infertility benefits for the remainder of your coverage.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Genetic Testing

Covered: Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

Hearing Services

Covered:

- Routine hearing examinations for members up to age 21.

Not Covered:

- Hearing aids.
- Routine hearing examinations for members age 21 and older.

Home Health Services

Covered: All of the following requirements must be met in order for home health services to be covered:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by Wellmark for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is referred by a Wellmark Blue POS Provider and approved by Wellmark.

The following are covered services and supplies:

Home Health Aide Services—when provided in conjunction with a medically necessary skilled service also received in the home.

Short-Term Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Short-term home skilled nursing means home skilled nursing care that:

- is provided for a definite limited period of time as a safe transition from other levels of care when medically necessary;
- provides teaching to caregivers for ongoing care; or
- provides short-term treatments that can be safely administered in the home setting.

The daily benefit for short-term home skilled nursing services will not exceed Wellmark’s daily maximum allowable fee for care in a skilled nursing facility. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered:

- Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitarium care or rest cures.
- Extended home skilled nursing.

See Also:

Referrals, page 48.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- The equipment is ordered by a provider within the scope of his or her license and there is a written prescription.
- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.
- Standard or basic home/durable medical equipment that will adequately meet the medical needs and that does

not have certain deluxe/luxury or convenience upgrade or add-on features.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Wellmark requires rental of certain medically appropriate home/durable medical equipment including, but not limited to, continuous positive airway pressure (CPAP) devices. When rental is required, you will be required to rent from a licensed DME provider for a period of ten months, and after the expiration of the ten-month period, Wellmark considers the item purchased. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies and Personal Convenience Items later in this section.

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Referrals, page 48.

Hospice Services

Covered: Care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice care covers the same services as described under *Home Health Services*, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital.

Benefits Maximum:

- **15 days** per lifetime for inpatient hospice respite care.
- **15 days** per lifetime for outpatient hospice respite care.
- Not more than **five days** of hospice respite care at a time.

Hospitals and Facilities

Covered: Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed and must be licensed as an ambulatory surgical facility under applicable law.

Chemical Dependency Treatment Facility. This type of facility must be licensed as a chemical dependency treatment facility under applicable law.

Community Mental Health Center. This type of facility provides treatment of mental health conditions and must be licensed as a community mental health center under applicable law.

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.

Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis for short-term care. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver. The facility must be licensed as a nursing facility under applicable law.

Psychiatric Medical Institution for Children (PMIC). This type of facility

provides inpatient psychiatric services to children and is licensed as a PMIC under Iowa Code Chapter 135H.

Urgent Care Center. This type of facility provides medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

Benefits Maximum:

- **90 days** per benefit year for skilled nursing services in a hospital or nursing facility.

Not Covered:

- Long Term Acute Care Facility.
- Room and board provided while a patient at an intermediate care facility or similar level of care.

Please note:

When the No Surprises Act applies to items and services from an Out-of-Network Provider at a participating facility, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illness or Injury Services

Covered:

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.
- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor’s office).
- Outpatient.

Not Covered:

- Long term acute care services typically provided by a long term acute care facility.
- Room and board provided while a patient at an intermediate care facility or similar level of care.
- Services and supplies associated with routine foot care except as described under *Covered*.

Inhalation Therapy

Covered: Respiratory or breathing treatments to help restore or improve breathing function.

Maternity Services

Covered: Prenatal care, delivery, and postpartum care, including complications of pregnancy. A complication of pregnancy refers to any maternity-related condition that is not diagnosed and coded as a normal

prenatal visit or a normal spontaneous vaginal delivery.

Please note: You must notify us or your group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your group sponsor or call the Customer Service number on your ID card.

In accordance with federal or applicable state law, maternity services include a minimum of:

- 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery, or
- 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

Coverage includes one follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

If you have a newborn child, but you do not add that child to your coverage, your newborn child may be added to your coverage solely for the purpose of administering benefits for the newborn during the first 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If that occurs, a separate deductible and coinsurance may be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child. If the newborn is added to or covered by and receives benefits under another plan, benefits will not be provided under this plan.

See Also:

Coverage Change Events, page 73.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies purchased from a covered provider.

Not Covered: Unless otherwise required by law, supplies, equipment, or drugs available for general retail purchase or items used for your personal convenience including, but not limited to:

- Band-aids, gauze, bandages, tape, non-sterile gloves, thermometers, heating pads, cooling devices, cold packs, heating devices, hot water bottles, home enema equipment, sterile water, bed boards, alcohol wipes, or incontinence products;
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription;
- Escalators, elevators, ramps, stair glides, emergency/alert equipment, handrails, heat appliances, improvements made to a member's house or place of business, or adjustments made to vehicles;
- Household supplies including, but not limited to: deluxe/luxury equipment or non-essential features, such as motor-driven chairs or bed, electric stair chairs or elevator chairs, or sitz bath;
- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury including, but not limited to, air conditioners, hot tubs, or swimming pools;
- Items that do not serve a medical purpose or are not needed to serve a medical purpose;

- Rental or purchase of equipment if you are in a facility which provides such equipment;
- Rental or purchase of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment, or traction devices; and
- Water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool, spa, air purifiers, humidifiers, dehumidifiers, or light devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics (Foot) later in this section.

Prescription Drugs, page 37.

Prosthetic Devices later in this section.

Medical Evacuation

Covered: Medical evacuation services if you become ill or have an injury at a location where adequate medical care cannot be provided. The medical evacuation generally will be to the nearest adequate medical facility. If you are from outside the United States, medical evacuation may be either to the nearest adequate medical facility or to your home country. This benefit applies to the student/scholar, spouse, domestic partner, or child covered under this medical benefits plan.

See Also:

Precertification, page 15.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers.

To qualify for mental health treatment benefits, the following requirements must be met:

- The disorder is classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) or subsequent revisions, except as otherwise provided in this coverage manual.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of *International Classification of Diseases, Clinical Modification* used for diagnosis coding.

Licensed Psychiatric or Mental Health Treatment Program Services. Benefits are available for mental health treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Individual, group, or family therapy provided in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Psychiatric observation;
- Care provided in a psychiatric residential crisis program;
- Care provided in a medically monitored intensive inpatient setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Services and supplies associated with certain disorders related to early childhood, such as academic underachievement disorder.
- Services and supplies associated with communication disorders, such as stuttering and stammering.
- Services and supplies associated with impulse control disorders.
- Services and supplies associated with conditions that are not pervasive developmental and learning disorders.
- Services and supplies associated with sensitivity, shyness, and social withdrawal disorders.
- Services and supplies associated with sexual disorders.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:

Chemical Dependency Treatment and Hospitals and Facilities earlier in this section.

Motor Vehicles

Not Covered: Purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Musculoskeletal Treatment

Covered: Outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Not Covered:

- Manipulations or related procedures to treat musculoskeletal injury or disease performed for maintenance.
- Massage therapy.

Nonmedical or Administrative Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Nutritional and Dietary Supplements

Covered:

- Nutritional and dietary supplements that cannot be dispensed without a prescription issued by or authorized by a licensed healthcare practitioner and are prescribed by a licensed healthcare practitioner for permanent inborn errors of metabolism, such as PKU.
- Enteral and nutritional therapy only when prescribed feeding is administered through a feeding tube, except for permanent inborn errors of metabolism.

Not Covered: Other prescription and non-prescription nutritional and dietary supplements including, but not limited to:

- Food products.
- Grocery items or food products that are modified for special diets for individuals with inborn errors of metabolism but which can be purchased without a prescription issued by or authorized by a licensed healthcare practitioner, including low protein/low phe grocery items.
- Herbal products.
- Fish oil products.

- Medical foods, except as described under *Covered*.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

Occupational Therapy

Covered: Occupational therapy services are covered when all the following requirements are met:

- Services are to treat the upper extremities, which means the arms from the shoulders to the fingers.
- The goal of the occupational therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation or habilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Occupational therapy performed for maintenance.
- Occupational therapy services that do not meet the requirements specified under *Covered*.

Orthotics (Foot)

Covered: Orthotics training, including assessment and fitting for covered orthotic devices.

Not Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Prosthetic Devices later in this section.

Physical Therapy

Covered: Physical therapy services are covered when all the following requirements are met:

- The goal of the physical therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation or habilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered:

- Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Physical therapy performed for maintenance.
- Physical therapy services that do not meet the requirements specified under *Covered*.

Physicians and Practitioners

Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

Advanced Registered Nurse

Practitioners (ARNP). An ARNP is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Licensed Marriage and Family Therapists.

Licensed Mental Health Counselors.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register.

Speech Pathologists.

See Also:

Choosing a Provider, page 47.

Prescription Drugs

Covered: Most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," are generally covered under your Blue Rx Value Plus prescription drug benefits, not under your medical benefits. However, there are exceptions when prescription drugs and medicines are covered under your medical benefits.

Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered. For a list of these drugs, visit our website at *Wellmark.com* or check with your pharmacist or physician.

Drugs listed on the Drug List are established and maintained by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is a group of independent practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety, effectiveness, and value of new and existing medications and make any necessary changes to the coverage of medications. Drugs will not be covered until they have been evaluated and approved to be covered by Wellmark's P&T Committee. Drugs previously approved by Wellmark's P&T Committee will no longer be covered if Wellmark's P&T Committee discontinues approval of the drugs.

Prescription drugs and medicines that may be covered under your medical benefits include:

Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Intravenous Administration.

Intravenous administration of nutrients, antibiotics, and other drugs and fluids

when provided in the home (home infusion therapy).

Specialty Drugs. Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration.

Specialty drugs may be covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits. If a specialty drug that is covered under your medical benefits is not provided by your physician, we recommend that you purchase specialty drugs through a participating pharmacy or through the specialty pharmacy program. To determine whether a particular specialty drug is covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card. See *Specialty Pharmacy Program*, page 55.

Take-Home Drugs. Take-home drugs are drugs dispensed and billed by a hospital or other facility for a short-term supply.

Not Covered: Some prescription drugs, services, and items are not covered under either your medical benefits or your Blue Rx Value Plus benefits. For example:

- Antigen therapy.
- Medication Therapy Management (MTM) when billed separately.
- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

- Prescription drugs or pharmacy durable medical equipment devices that are not FDA-approved.
- Prescription drugs that are not approved to be covered by Wellmark's P&T Committee.

Some prescription drugs are covered under your Blue Rx Value Plus benefits:

- Insulin.
- See the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com* or call the Customer Service number on your ID card and request a copy of the Drug List.

See Also:

Contraceptives earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Notification Requirements and Care Coordination, page 57.

Prescription Drugs later in this section.

Prior Authorization, page 61.

Preventive Care

Covered: Preventive care such as:

- Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- Digital breast tomosynthesis (3D mammogram).
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.

- Preventive items and services including, but not limited to:
 - Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
 - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
 - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
 - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Benefits Maximum:

- Well-child care until the child reaches age seven.
- **One** routine physical examination per benefit year.
- **One** routine mammogram per benefit year.
- **One** routine gynecological examination per benefit year.
- **One** routine Pap smear per benefit year.

Please note: Physical examination limits do not include items or services with an “A” or “B” rating in the current

recommendations of the USPSTF, immunizations as recommended by ACIP, and preventive care and screening guidelines supported by the HRSA, as described under *Covered*.

Not Covered:

- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel, or other administrative purposes.
- Group lactation consultant services.
- All services and supplies associated with nicotine dependence, except as described under *Covered*. For prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician, please see your Blue Rx Value Plus prescription drug benefits.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

Covered: Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

Also covered are braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

- Devices such as air conduction hearing aids or examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Orthotics (Foot) earlier in this section.

Referrals, page 48.

Reconstructive Surgery

Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:

Cosmetic Services earlier in this section.

Repatriation

Covered: In the event of death, the expenses related to the return of the body of the member to their place of origin or citizenship is covered. For further instructions on utilizing this service, call the Customer Service number on your ID card.

Not Covered: This benefit does not include the transportation expenses of persons accompanying the body.

See Also:

Medical Evacuation earlier in this section.

Self-Help Programs

Not Covered: Self-help and self-cure products or drugs.

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

Not Covered: Treatment for snoring without a diagnosis of obstructive sleep apnea.

Social Adjustment

Not Covered: Services or supplies intended to address social adjustment or economic needs that are typically not medical in nature.

Speech Therapy

Covered: Rehabilitative or habilitative speech therapy services when related to a specific illness, injury, or impairment, including speech therapy services for the treatment of autism spectrum disorder, that involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered:

- Speech therapy services not provided by a licensed or certified speech pathologist.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

Surgery

Covered. This includes the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

Not Covered:

- Bariatric surgery.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

Covered: You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification or by a practitioner contracting through Doctor on Demand via real-time, interactive audio-visual technology, web-based mobile device or similar electronic-based communication network, or as otherwise required by Iowa law. Services must be delivered in accordance with applicable law and generally accepted health care practices.

Please note: Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

Not Covered: Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Services and supplies associated with routine dental care, dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Covered:

- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.

- Simultaneous pancreas/kidney.
- Small bowel.

You are also covered for the medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.

Transplants are subject to care management.

Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by your medical benefits.

Please note: To qualify for benefits, the transplant facility services specified under *Covered* must be from a facility recognized as a Blue Distinction® Center for Transplants at the time of service. This requirement does not apply to small bowel transplants or for practitioner services.

Not Covered:

- Expenses of transporting the recipient when the transplant organ for the recipient is not available for transplant.
- Expenses of transporting a living donor.
- Expenses related to the purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services and supplies not listed in this section including complications.

See Also:

Ambulance Services earlier in this section.

Care Management, page 61.

Referrals, page 48.

Travel or Lodging Costs later in this section.

Travel or Lodging Costs

Covered: Travel or lodging costs are covered only when related to a transplant.

Benefits Maximum:

- **\$10,000** per transplant.

Not Covered: Travel and lodging costs unrelated to a covered transplant.

See Also:

Transplants earlier in this section.

Vision Services

Covered:

- Routine vision and refraction examinations.
- Eyeglasses, but only when prescribed as the result of cataract extraction.
- Contact lenses and associated lens fitting, but only when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or corneal disease.

Benefits Maximum:

- **One** routine vision examination per benefit year.

Not Covered:

- Surgery and services to diagnose or correct a refractive error, including intraocular lenses and laser vision correction surgery (e.g., LASIK surgery).
- Eyeglasses, contact lenses, or the examination for prescribing or fitting of eyeglasses or contact lenses, except when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or disease.

Wigs or Hairpieces

Covered: Wigs and hairpieces are covered but only when related to hair loss resulting from medical treatment.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

Prescription Drugs

Guidelines for Drug Coverage

To be covered, a prescription drug or pharmacy durable medical equipment device must meet all of the following criteria:

- Listed on the Wellmark Blue Rx Value Plus Drug List.
- Can be legally obtained in the United States only with a written prescription.
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962.
- Prescribed by a practitioner prescribing within the scope of his or her license.
- Dispensed by a recognized licensed retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program, or dispensed and billed by a hospital or other facility as a take-home drug for a short-term supply.
- Medically necessary for your condition. See *Medically Necessary*, page 41.
- Not available in an equivalent over-the-counter strength. However, certain over-the-counter products and over-the-counter nicotine dependency drugs prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call

the Customer Service number on your ID card.

- Reviewed, evaluated, and recommended for addition to the Wellmark Blue Rx Value Plus Drug List by Wellmark.

Drugs that are Covered

The Wellmark Blue Rx Value Plus Drug List

The Wellmark Blue Rx Value Plus Drug List is a reference list that includes generic and brand-name prescription drugs and pharmacy durable medical equipment devices that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Value Plus prescription drug benefits. The Wellmark Blue Rx Value Plus Drug List is established and maintained by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is an independent group of practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety, effectiveness, and value of new and existing medications and make any necessary changes to the Drug List. The Drug List is updated following review by Wellmark's P&T Committee of FDA decisions or approvals on new and existing drugs. Changes to the Drug List may also occur when new versions or generic versions of existing drugs become available, new safety concerns arise, and as discontinued drugs are removed from the marketplace. Additional changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier/level) occur semi-annually.

To determine if a drug is covered, you must consult the Wellmark Blue Rx Value Plus Drug List. You are covered for drugs listed on the Wellmark Blue Rx Value Plus Drug List. If a drug is not on the Wellmark Blue Rx Value Plus Drug List, it is not covered.

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website,

Wellmark.com, or call the Customer Service number on your ID card and request a copy of the Drug List.

The Drug List is subject to change.

Preventive Items and Services

Preventive items and services received at a licensed retail pharmacy, including certain items or services recommended with an "A" or "B" rating by the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration are covered. To determine if a particular preventive item or service is covered, consult the Wellmark Blue Rx Value Plus Drug List or call the Customer Service number on your ID card.

Specialty Drugs

Specialty drugs are high-cost injectable, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They are not available through the mail order drug program.

Specialty drugs may be covered under your Blue Rx Value Plus prescription drug benefits or under your medical benefits. To determine whether a particular specialty drug is covered under your Blue Rx Value Plus prescription drug benefits or under your medical benefits, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, check with your pharmacist or physician, or call the Customer Service number on your ID card.

Nicotine Dependency Drugs

Prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician are covered.

Benefits Maximum: 180-days' supply of covered over-the-counter drugs for smoking cessation per calendar year.

Limits on Prescription Drug Coverage

We may exclude, discontinue, or limit coverage for any drug by removing it from the Drug List or by moving a drug to a different tier on the Drug List for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- Over-the-counter drugs with similar properties become available or a drug's active ingredient is available in a similar strength in an over-the-counter product or as a nutritional or dietary supplement product available over the counter.
- There is a sound medical reason.
- Scientific evidence does not show that a drug works as well and is as safe as other drugs used to treat the same or similar conditions.
- A drug receives FDA approval for a new use.

Drugs, Services, and Items that are Not Covered

Drugs, services, and items that are not covered under your prescription drug benefits include, but are not limited to:

- Drugs not listed on the Wellmark Blue Rx Value Plus Drug List.
- Drugs in excess of a quantity limitation. See *Quantity Limitations* later in this section.
- Antigen therapy.
- Drugs that are not FDA-approved.
- Drugs that are not approved to be covered by Wellmark's P&T Committee.
- Investigational or experimental drugs.
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain.

- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug.
- Drugs determined to be abused or otherwise misused by you.
- Drugs that are lost, damaged, stolen, or used inappropriately.
- Contraceptive medical devices, such as intrauterine devices and diaphragms. These are covered under your medical benefits. See *Contraceptives*, page 21.
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.
- Cosmetic drugs.
- Infused drugs. These may be covered under your medical benefits. See *Specialty Drugs*, page 33.
- Irrigation solutions and supplies.
- Medication Therapy Management (MTM) when billed separately.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Weight reduction drugs.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

- Mail order prescription drugs.

See Also:

Prescription Drugs, page 32.

Prescription Purchases Outside the United States

To qualify for benefits for prescription drugs purchased outside the United States, all of the following requirements must be met:

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same

name and dosage form as the FDA-approved drug's active ingredient.

- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician.

In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs with quantity limits, check with your pharmacist or physician, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

Refills

To qualify for refill benefits, all of the following requirements must be met:

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your practitioner.

- The refill is not limited by state law. You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time.

If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the United States, the refill amount will not exceed a 90-day supply.

To receive authorization for an early refill, ask your pharmacist to call us.

4. General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

Conditions of Coverage

Medically Necessary

A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Wellmark's medically necessary analysis and determinations apply to any service, supply, device, or drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. Even though a provider may recommend a service or supply, it may not be medically necessary.

A medically necessary health care service is one that a provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and satisfies all of the following criteria:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - Nationally recognized utilization management standards as utilized by Wellmark; or
 - Wellmark's published Medical and Drug Policies as determined applicable by Wellmark; or
 - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
 - Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
 - Not provided primarily for the convenience of the patient, physician, or other health care provider, and
 - Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.
- An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.
- If you receive services that are not medically necessary, you are responsible for the cost if:
- You receive the services from an Out-of-Network Provider; or
 - You receive the services from a Wellmark Blue POS or Participating provider and:
 - The provider informs you in writing before rendering the services that

- Wellmark determined the services to be not medically necessary; and
- The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the Wellmark Blue POS or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from an Out-of-Network Provider that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Member Eligibility

Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 71.

General Exclusions

Even if a service, supply, device, or drug is listed as otherwise covered in *Details - Covered and Not Covered*, it is not eligible for benefits if any of the following general exclusions apply.

Investigational or Experimental

You are not covered for a service, supply, device, biological product, or drug that is investigational or experimental. You are also not covered for any care or treatments related to the use of a service, supply, device, biological product, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine. Our analysis of whether a service, supply, device, biological

product, or drug is considered investigational or experimental is applied to medical, surgical, mental health, and chemical dependency treatment services, as applicable.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross Blue Shield Association, including whether a service, supply, device, biological product, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning its effect on health outcomes.
- It improves the net health outcome.
- It is as beneficial as any established alternatives.
- The health improvement is attainable outside the investigational setting.

These criteria are considered by the Blue Cross Blue Shield Association's Medical Advisory Panel for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other Blue Cross and Blue Shield member organizations. You may access our medical policies, with supporting information and selected medical references for a specific service, supply, device, biological product, or drug through our website, Wellmark.com.

If you receive services that are investigational or experimental, you are responsible for the cost if:

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a Wellmark Blue POS or Participating provider and:

- The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and
- The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the Wellmark Blue POS or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from an Out-of-Network Provider that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.

See Also:

Clinical Trials, page 21.

Complications of a Noncovered Service

You are not covered for a complication resulting from a noncovered service, supply, device, or drug. However, this exclusion does not apply to the treatment of complications resulting from:

- Smallpox vaccinations when payment for such treatment is not available through workers' compensation or government-sponsored programs; or
- A noncovered abortion.

Nonmedical or Administrative Services

You are not covered for telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative

services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Provider Is Family Member

You are not covered for a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner).

Covered by Other Programs or Laws

You are not covered for a service, supply, device, or drug if:

- Someone else has the legal obligation to pay for services, has an agreement with you to not submit claims for services or, without this group health plan, you would not be charged.
- You require services or supplies for an illness or injury sustained while on active military status.

Workers' Compensation

You are not covered for services or supplies for which we learn or are notified by you, your provider, or our vendor that such services or supplies are related to a work related illness or injury, including services or supplies applied toward satisfaction of any deductible under your group sponsor's workers' compensation coverage. We will comply with our statutory obligation regarding payment on claims on which workers' compensation liability is unresolved. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if:

- you did not comply with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization; or
- you rejected workers' compensation coverage.

The exclusion for services or supplies related to work related illness or injury does

not exclude coverage for such illness or injury if you are exempt from coverage under Iowa's workers' compensation statutes pursuant to Iowa Code Section 85.1 (1)-(4), unless you or your employer has elected or obtained workers' compensation coverage as provided in Iowa Code Section 85.1(6).

For treatment of complications resulting from smallpox vaccinations, see *Complications of a Noncovered Service* earlier in this section.

Wellmark Medical and Drug Policies

Wellmark maintains Medical and Drug Policies that are applied in conjunction with other resources to determine whether a specific service, supply, device, biological product, or drug is a covered service under the terms of this coverage manual. These policies are hereby incorporated into this coverage manual. You may access these policies along with supporting information and selected medical references through our website, *Wellmark.com*.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this group health plan. These amounts are not credited toward your out-of-pocket maximum. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 19.
- If you receive benefits that reach a lifetime benefits maximum applicable to any specific service, then you are no longer eligible for benefits for that service under this group health plan. See

Benefits Maximums, page 9, and *At a Glance—Covered and Not Covered*, page 15.

- If you do not obtain precertification for certain medical services, benefits can be denied. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A Wellmark Blue POS Provider in the Wellmark Blue POS network will handle notification requirements for you. If you see a provider outside the Wellmark Blue POS network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 57.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.
You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A Wellmark Blue POS Provider in the Wellmark Blue POS network will handle notification requirements for you. If you see a provider outside the Wellmark Blue POS network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 57.
- If you do not obtain prior authorization for certain prescription drugs, benefits can be denied. See *Notification*

Requirements and Care Coordination,
page 57.

- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 47, and *Factors Affecting What You Pay*, page 63. An example of a charge that depends on the type of provider includes, but is not limited to:
 - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network Provider.

5. Choosing a Provider

Medical

Provider Network

Under the medical benefits of this plan, your network of providers consists of domestic providers, Wellmark Blue POS and Participating providers. All other providers are not in your network. Which provider type you choose will affect what you pay.

Providers who do not participate with the network utilized by these medical benefits are called Out-of-Network Providers.

Blue Choice allows you to receive covered services from almost any provider who is eligible to provide the services. However, there are different levels of benefits depending on the type of provider you use:

Level 1 – You receive services from a domestic provider.

Level 2 – Generally, you will receive this payment level when you do not receive services from a domestic provider, but receive services from a Wellmark Blue POS Provider or you receive services from a Participating or Out-of-Network provider with a Wellmark-approved referral.

Level 3 – Generally, you will receive this payment level when you do not receive services from a domestic provider or a Wellmark Blue POS Provider. This level offers the lowest payment for benefits.

There may be exceptions for certain covered services. These exceptions are explained in *What You Pay*, page 5.

It is usually to your advantage to receive services from a domestic provider or a Wellmark Blue POS Provider. If you are unable to utilize a Wellmark Blue POS Provider, we recommend you receive services from a Participating Provider. Although you may pay more for services you receive from a Participating Provider, you

will usually pay the most for services received from an Out-of-Network Provider.

Participating Providers participate with a Blue Cross and/or Blue Shield Plan, but not with the Wellmark Blue POS network.

To determine if a provider participates with this medical benefits plan, ask your provider, refer to our online provider directory at *Wellmark.com*, or call the Customer Service number on your ID card. Our provider directory is also available upon request by calling the Customer Service number on your ID card.

To determine if a provider is part of your employer's domestic network, ask your provider or ask your employer.

Providers are independent contractors and are not agents or employees of Wellmark Health Plan of Iowa, Inc. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 26 and *Physicians and Practitioners*, page 32.

Please note: Even if a specific provider type is not listed as a recognized provider type, Wellmark does not discriminate against a licensed health care provider acting within the scope of his or her state license or certification with respect to coverage under this plan.

Please note: Even though a facility may be a Wellmark Blue POS network facility, particular providers within the facility may not be Wellmark Blue POS Providers. Examples include Out-of-Network physicians on the staff of a Wellmark Blue POS network hospital, home medical equipment suppliers, and other independent providers. Therefore, when you are referred by a Wellmark Blue POS Provider to another provider, or when you

are admitted into a facility, always ask if the providers are Wellmark Blue POS Providers.

Always carry your ID card and present it when you receive services. Information on it, especially the ID number, is required to process your claims correctly.

Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. See *Choosing a Pharmacy* and *Specialty Pharmacy Program* later in this section.

Blue Distinction Centers

Blue Distinction Centers (BDC) met overall quality measures, developed with input from the medical community. A local Blue Plan may require additional criteria for

providers located in its own service area; for details, contact your local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its local Blue Plan. Providers in California, Idaho, New York, Pennsylvania, and Washington may lie in two local Blue Plans' areas, resulting in two evaluations for cost of care; and their own local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own coverage, contact your local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for noncovered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

Provider Comparison Chart	Domestic Providers	Wellmark Blue POS Providers	Participating	Out-of-Network
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	Yes	Yes	No
Minimizes your payment obligations. See <i>What You Pay</i> , page 5.	Yes	Yes	No	No
Claims are filed for you.	Yes	Yes	Yes	No
Blue Cross and/or Blue Shield pays these providers directly.	Yes	Yes	Yes	No
Notification requirements are handled for you.	Yes	Yes	Yes*	No

*If you are admitted to a Participating facility outside the Wellmark Blue POS network, Participating Providers should handle notification requirements for you.

Referrals

If you require services from a provider other than a primary care provider, typically a specialist, you may see a provider in the Wellmark Blue POS network. If there are no providers in the Wellmark Blue POS

network who can treat your condition, you will be referred to a provider outside the Wellmark Blue POS network who has expertise in diagnosing and treating your condition. Wellmark must approve referrals outside of the Wellmark Blue POS network before you receive services in order to

receive Benefit Level 2. Otherwise, you will receive Benefit Level 3. **Please note:** Even when your referral outside the Wellmark Blue POS network is approved, you are still responsible for complying with notification requirements. See *Notification Requirements and Care Coordination*, page 57. **Please note:** Even when your referral outside the Wellmark Blue POS network is approved, you may be responsible for the difference between the amount an Out-of-Network Provider bills and our payment amount.

Services Outside the Wellmark Blue POS Network

BlueCard Program

This program ensures that members of any Blue Plan have access to the advantages of Participating Providers throughout the United States. Participating Providers have a contractual arrangement with the Blue Cross and/or Blue Shield Plan in their home state (“Host Blue”). The Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program is one of the advantages of your coverage with Wellmark Health Plan of Iowa, Inc. It provides conveniences and benefits outside the Wellmark Blue POS network area similar to those you would have in the Wellmark Blue POS network area when you obtain covered medical services from a Wellmark Blue POS Provider. Always carry your ID card (or BlueCard) and present it to your provider when you receive care. Information on it, especially the ID number, is required to process your claims correctly.

In an emergency situation, seek care at the nearest hospital emergency room. Whenever possible, before receiving services outside the Wellmark Blue POS network, you should always ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate

Participating Providers in any state, call **800-810-BLUE**, or visit www.bcbs.com.

When you receive covered services from Participating Providers outside the Wellmark Blue POS network, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The group health plan payment is sent directly to the providers.
- Wellmark requires claims to be filed within 180 days following the date of service (or 180 days from date of discharge for inpatient claims). However, if the Participating Provider’s contract with the Host Blue has a requirement that a claim be filed in a timeframe exceeding 180 days following the date of service or date of discharge for inpatient claims, Wellmark will process the claim according to the Host Blue’s contractual filing requirement. If you receive services from an Out-of-Network Provider, the claim has to be filed within 180 days following the date of service or date of discharge for inpatient claims.

Typically, when you receive covered services from Participating Providers outside the Wellmark Blue POS network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 57. However, if you are admitted to a BlueCard facility outside the Wellmark Blue POS network, any Participating Provider should handle notification requirements for you.

Wellmark Health Plan of Iowa, Inc., is an affiliate of Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, independent licensees of the Blue Cross Blue Shield Association. We have a variety of relationships with other Blue

Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates (“Licensees”). Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”).

Whenever you obtain healthcare services outside the Wellmark Blue POS network, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers (“Participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“Out-of-Network Providers”) don’t contract with the Host Blue. In the following paragraphs we explain how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described previously, except for all dental care benefits (except when paid as medical benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you receive out-of-area covered services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program enables you to obtain covered out-of-area services, as defined previously in this section, from a healthcare provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the covered out-of-area services

provided to you, so there are no claim forms for you to fill out. You will be responsible for your payment obligations. See *Referrals* earlier in this section. In addition notification requirements may apply, See *Notification Requirements and Care Coordination*, page 57.

Emergency Care Services: If you experience a medical emergency while traveling outside the Wellmark Blue POS network, go to the nearest emergency or urgent care facility.

When you receive covered out-of-area services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for the covered out-of-area services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed charges for your out-of-area covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted previously. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside the Wellmark Service Area

Your Liability Calculation. When covered out-of-area services are provided outside of our service area by Out-of-Network Providers, the amount you pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered out-of-area services as set forth in this coverage manual.

An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 7. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and

intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

In certain situations, we may use other payment methods, such as billed charges for covered out-of-area services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by Out-of-Network Providers. In these situations, you may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered out-of-area services as set forth in this coverage manual.

You are entitled to benefits for services that you receive either inside or outside the Wellmark Blue POS network if your medical benefits cover those services. Due to variations in Host Blue network protocols, you may also be entitled to benefits for some services obtained outside the Wellmark Blue POS network, even though you might not otherwise have been entitled to benefits if you had received those services inside the Wellmark Blue POS network. But in no event will you be entitled to benefits for services, wherever you received them, that are specifically excluded from, or in excess of the limits of, coverage provided by your medical benefits.

Care in a Foreign Country

For covered services you receive in a country other than the United States, payment level assumes the provider category is Out-of-Network except for services received from providers that participate with Blue Cross Blue Shield Global Core.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S.

Virgin Islands, you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services. In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. **You must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the United States, the

Commonwealth of Puerto Rico, and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 77.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered services outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the Blue Cross Blue Shield Global Core Service Center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week.

Out-of-Area Services

You are eligible for Benefit Level 2 for covered services received from Out-of-Network or Participating providers (including out-of-country providers) only in the following situations:

- **Accidental Injuries.**
- **Emergencies.** If you cannot reasonably reach a domestic network or Wellmark Blue POS Provider, it is in your best interest to seek care from a Participating Provider. Participating Providers participate with a Blue Cross and/or Blue Shield Plan, but not with the Wellmark Blue POS network.

Out-of-Network Providers do not participate with this plan or any other Blue Cross and/or Blue Shield Plan.

For information on how benefits for accidental injuries and emergency services will be administered when received outside of the Wellmark Blue POS network, see *BlueCard Program* earlier in this section and *Out-of-Network Providers*, page 64.

When you receive covered services for emergency medical conditions from Out-of-Network Providers, all of the following statements are true:

- Out-of-Network Providers are not responsible for filing your claims.
- We do not have contracts with Out-of-Network Providers and they may not agree to accept our payment arrangements. Therefore, you may be responsible for any difference between the amount charged and our payment.
- We make claims payments to you, not Out-of-Network Providers.
- You are responsible for notification requirements.

- **Referrals.** See *Referrals* earlier in this section.

Guest Membership. Members traveling long-term, any covered dependents attending college out of state, or covered family members living apart are eligible to become a guest member any time they are outside the Wellmark Blue POS network area for at least 90 days. Not all services covered under your medical benefits are covered under Guest Membership. To determine which services are covered under the Guest Membership program, call us.

To receive covered services under the Guest Membership program, you must receive the service(s) from a Participating Provider.

Before you leave the Wellmark Blue POS network area, call the Customer Service number on your ID card to set up a guest membership.

Laboratory services. You may have laboratory specimens or samples collected by a Wellmark Blue POS Provider and those laboratory specimens may be sent to another laboratory services provider for processing or testing. If that laboratory services provider does not have a contractual relationship with the Blue Plan where the specimen was drawn,* Benefit Level 3 may apply and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

*Where the specimen is drawn will be determined by which state the referring provider is located.

Home/durable medical equipment. If you purchase or rent home/durable medical equipment from a provider that does not have a contractual relationship with the Blue Plan where you purchased or rented the equipment, Benefit Level 3 may apply and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the home/durable medical equipment provider, Benefit Level 3 may apply and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in the Wellmark Blue POS network, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

Prosthetic devices. If you purchase prosthetic devices from a provider that does not have a contractual relationship with the Blue Plan where you purchased the prosthetic devices, Benefit Level 3 may apply and you may also be responsible for any difference between the amount charged

and our amount paid for the covered service.

If you purchase prosthetic devices and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the provider, Benefit Level 3 may apply and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase prosthetic devices and have them shipped to you in the Wellmark Blue POS network, when Wellmark does not have a contractual relationship with the provider.

Talk to your provider. Whenever possible, before receiving laboratory services, home/durable medical equipment, or prosthetic devices, ask your provider to utilize a provider that has a contractual arrangement with the Blue Plan where you received services, purchased or rented equipment, or shipped equipment, or ask your provider to utilize a provider that has a contractual arrangement with Wellmark.

To determine if a provider has a contractual arrangement with a particular Blue Plan or with Wellmark, call the Customer Service number on your ID card or visit our website, *Wellmark.com*.

See *Out-of-Network Providers*, page 64.

Continuity of Care

If you are a Continuing Care Patient

- undergoing a course of treatment for a serious or complex condition,
- undergoing a course of institutional or inpatient care,
- scheduled to undergo nonelective surgery, including postoperative care with respect to such surgery,

- pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery, or
- receiving treatment for a terminal illness and, with respect to the provider or facility providing such treatment:
 - the network agreement between the provider or facility and Wellmark is terminated; or
 - benefits provided under this plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage;

then you may elect to continue to have benefits provided under this plan under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the plan as if the termination resulting in out-of-network status had not occurred. This Continuity of Care applies only with respect to the course of treatment furnished by such provider or facility relating to the condition affecting an individual's status as a Continuing Care Patient. Claims for treatment of the condition from the provider or facility will be considered in-network claims until the earlier of (i) the date you are no longer considered a Continuing Care Patient, or (ii) the end of a 90 day period beginning on the date you have been notified of your opportunity to elect transitional care.

In order to elect transitional care as a Continuing Care Patient, you may respond to the letter Wellmark sends you, or you or your provider may call us at **800-552-3993**.

Prescription Drugs

Choosing a Pharmacy

Your prescription drug benefits are called Blue Rx Value Plus. Pharmacies that

participate with the network used by Blue Rx Value Plus are called participating pharmacies. Pharmacies that do not

participate with the network are called nonparticipating pharmacies.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Blue Rx Value Plus allows you to purchase most covered prescription drugs from almost any pharmacy you choose. However, you will usually pay more for prescription drugs when you purchase them from nonparticipating pharmacies. Remember, you are responsible for the entire cost if you purchase a drug that is not on the Wellmark Drug List. We recommend you:

- Fill your prescriptions at a participating retail pharmacy or through the specialty pharmacy program. See *Specialty Pharmacy Program* later in this section.
- Advise your physician that you are covered under Blue Rx Value Plus.
- Always present your ID card when filling prescriptions. Your ID card enables participating pharmacists to access your benefits information.

Advantages of Visiting Participating Pharmacies

When you fill your prescription at participating pharmacies:

- You will usually pay less. If you use a nonparticipating pharmacy, you must pay the amount charged at the time of purchase, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- The participating pharmacist can check whether your prescription is subject to prior authorization or quantity limits.
- The participating pharmacist can access your benefit information, verify your eligibility, check whether the prescription is a benefit under your Blue Rx Value Plus prescription drug benefits, list the amount you are

expected to pay, and suggest generic alternatives.

Always Present Your ID Card

If you do not have your ID card with you when you fill a prescription at a participating pharmacy, the pharmacist may not be able to access your benefit information. In this case:

- You must pay the full amount charged at the time you receive your prescription, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- You must file your claim to be reimbursed. See *Claims*, page 77.

Specialty Pharmacy Program

Specialty drugs are often unavailable from ordinary retail pharmacies. Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. We recommend that you purchase specialty drugs through a participating pharmacy or through the specialty pharmacy program. You must register as a specialty pharmacy program user in order to fill your prescriptions through the specialty pharmacy program. For information on how to register, call the Customer Service number on your ID card or visit our website at *Wellmark.com*.

The specialty pharmacy program administers the distribution of specialty drugs to the home and to physicians' offices.

When you fill your prescription through the specialty pharmacy program, you will usually pay less than if you use a pharmacy outside the specialty pharmacy program. For specialty drug purchases, pharmacies outside the specialty pharmacy program are considered nonparticipating pharmacies. When you purchase covered drugs from nonparticipating pharmacies, you will usually pay more.

When you purchase covered drugs from nonparticipating pharmacies you are responsible for the amount charged for the drug at the time you fill your prescription,

and then you must file a claim to be reimbursed. Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug, less your payment obligation. The maximum allowable fee may be less than the amount you paid. In other words, you are responsible for any difference in cost between what the pharmacy charges you for the drug and our reimbursement amount.

See *Participating vs. Nonparticipating Pharmacies*, page 69.

6. Notification Requirements and Care Coordination

Medical

Many services including, but not limited to, medical, surgical, mental health, and chemical dependency treatment services, require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical. For a complete list of services subject to notification or review, visit *Wellmark.com* or call the Customer Service number on your ID card.

Providers and Notification Requirements

Providers in the Wellmark Blue POS network should handle notification requirements for you. If you are admitted to a Participating facility outside the Wellmark Blue POS network, the Participating Provider should handle notification requirements for you.

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a Participating Provider outside the Wellmark Blue POS network, or if you see an Out-of-Network Provider, you or someone acting on your behalf is responsible for notification requirements.

More than one of the notification requirements and care coordination programs described in this section may apply to a service. Any notification or care coordination decision is based on the medical benefits in effect at the time of your request. If your coverage changes for any reason, you may be required to repeat the notification process.

You or your authorized representative, if you have designated one, may appeal a denial of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 87. Also see *Authorized Representative*, page 95.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. Precertification is required; however, it does not apply to maternity or emergency services.
Applies to	For a complete list of the services subject to precertification, visit <i>Wellmark.com</i> or call the Customer Service number on your ID card.

Person Responsible for Obtaining Precertification	<p>You or someone acting on your behalf is responsible for obtaining precertification if:</p> <ul style="list-style-type: none"> ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to precertification from a Participating Provider outside the Wellmark Blue POS network. <p>Your Provider should obtain precertification for you if:</p> <ul style="list-style-type: none"> ■ You receive services subject to precertification from a Wellmark Blue POS Provider in Iowa; or ■ You receive inpatient services subject to precertification from a Participating Provider outside the Wellmark Blue POS network. <p>Please note: If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.</p>
Process	<p>When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services.</p> <p>Wellmark will respond to a precertification request within:</p> <ul style="list-style-type: none"> ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. <p>Precertification requests must include supporting clinical information to determine medical necessity of the service or admission.</p> <p>After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.</p>
Importance	<p>If you choose to receive services subject to precertification, you will be responsible for the charges as follows:</p> <ul style="list-style-type: none"> ■ If you receive services subject to precertification from an Out-of-Network Provider and we determine that the procedure was not medically necessary you will be responsible for the full charge. <p>Denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See <i>What You Pay</i>, page 5.</p>

Notification

Purpose	Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.
Applies to	For a complete list of the services subject to notification, visit <i>Wellmark.com</i> or call the Customer Service number on your ID card.
Person Responsible	<p>Wellmark Blue POS Providers perform notification for you. However, you or someone acting on your behalf is responsible for notification if:</p> <ul style="list-style-type: none"> ■ You receive services subject to notification from a provider outside the Wellmark Blue POS network.

Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services or as soon as reasonably possible thereafter.
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Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.
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Applies to	<p>For a complete list of the services subject to prior approval, visit <i>Wellmark.com</i> or call the Customer Service number on your ID card.</p> <p>Please note: If a prior approval request is submitted for services that require a facility to have a Blue Distinction Center (BDC) designation for facility services to be covered, the prior approval request will be returned to your treating physician if the request is for facility services to be performed at a non-BDC facility. You should work with your treating physician to confirm the facility services for the planned procedure will be performed at a facility that has a BDC designation.</p>
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Person Responsible for Obtaining Prior Approval	<p>You or someone acting on your behalf is responsible for obtaining prior approval if:</p> <ul style="list-style-type: none"> ■ You receive services subject to prior approval from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to prior approval from a Participating Provider outside the Wellmark Blue POS network. <p>Your Provider should obtain prior approval for you if:</p> <ul style="list-style-type: none"> ■ You receive services subject to prior approval from a Wellmark Blue POS Provider in Iowa; or ■ You receive inpatient services subject to prior approval from a Participating Provider outside the Wellmark Blue POS network. <p>Please note: If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.</p>
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Process	<p>When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.</p> <p>Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within:</p> <ul style="list-style-type: none"> ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. <p>Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.</p>
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Importance	<p>If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial.</p> <p>If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval.</p> <p>Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the <i>Appeals</i> section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits.</p> <p>Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.</p> <p>Note: When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See <i>Precertification</i> and <i>Notification</i> earlier in this section.</p>
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Concurrent Review

Purpose	Concurrent review is a utilization review conducted during a member's facility stay or course of treatment at home or in a facility setting to determine whether the place or level of service is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	For a complete list of the services subject to concurrent review, visit <i>Wellmark.com</i> or call the Customer Service number on your ID card.
Person Responsible	Wellmark
Process	<p>Wellmark may review your case to determine whether your current level of care is medically necessary.</p> <p>Responses to Wellmark's concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.</p>
Importance	Wellmark may require a change in the level or place of service in order to continue providing benefits. If we determine that your current facility setting or level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.

Care Management

Purpose	Care management is intended to identify and assist members with the most severe illnesses or injuries by collaborating with members, members' families, and providers to develop individualized care plans.
Applies to	A wide group of members including those who have experienced potentially preventable emergency room visits; hospital admissions/readmissions; those with catastrophic or high cost health care needs; those with potential long term illnesses; and those newly diagnosed with health conditions requiring lifetime management. Examples where care management might be appropriate include but are not limited to: Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Pregnancy (high risk) Transplants
Person Responsible	You, your physician, and the health care facility can work with Wellmark's care managers. Wellmark may initiate a request for care management.
Process	Members are identified and referred to the Care Management program through Customer Service and claims information, referrals from providers or family members, and self-referrals from members.
Importance	Care management is intended to identify and coordinate appropriate care and care alternatives including reviewing medical necessity; negotiating care and services; identifying barriers to care including contract limitations and evaluation of solutions outside the group health plan; assisting the member and family to identify appropriate community-based resources or government programs; and assisting members in the transition of care when there is a change in coverage.

Prescription Drugs

Prior Authorization of Drugs

Purpose	Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary.
Applies to	Consult the Drug List to determine if a particular drug requires prior authorization. You can locate this list by visiting <i>Wellmark.com</i> . You may also check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.
Person Responsible	You are responsible for prior authorization.

Process Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription. Nonparticipating pharmacists will fill a prescription without prior authorization but you will be responsible for paying the charge.

Wellmark will respond to a prior authorization request within:

- 72 hours in a medically urgent situation.
- 15 days in a non-medically urgent situation.

Calls received after 4:00 p.m. are considered the next business day.

Importance If you purchase a drug that requires prior authorization but do not obtain prior authorization, you are responsible for paying the entire amount charged.

7. Factors Affecting What You Pay

How much you pay for covered services is affected by many different factors discussed in this section.

Medical

Benefit Year

A benefit year is a period of 12 consecutive months beginning on August 1 or beginning on the day your coverage goes into effect. The benefit year starts over each August 1. Your benefit year continues even if your group sponsor changes Wellmark group health plan benefits during the year or you change to a different plan offering mid-benefit year from your same group sponsor.

Certain coverage changes result in your Wellmark identification number changing. In some cases, a new benefit year will start under the new ID number for the rest of the benefit year. In this case, the benefit year would be less than a full 12 months. In other cases (e.g., adding your spouse to your coverage) the benefit year would continue and not start over.

If you are an inpatient in a covered facility on the date of your annual benefit year renewal, your benefit limitations and payment obligations, including your deductible and out-of-pocket maximum, for facility services will refresh. This means that for facility services, as of your annual benefit year renewal, your benefit limitations and payment obligation amounts, including your deductible and out-of-pocket maximum, will be based on the amounts in effect on the date you were admitted. However, your payment obligations, including your deductible and out-of-pocket maximum, for practitioner services will be based on the payment obligation amounts in effect on the day you receive services.

The benefit year is important for calculating:

- Deductible.

- Coinsurance.
- Out-of-pocket maximum.
- Benefits maximum.

How Coinsurance is Calculated

The amount on which coinsurance is calculated depends on the state where you receive a covered service and the contracting status of the provider.

Wellmark Blue POS and Out-of-Network Providers

Coinsurance is calculated using the payment arrangement amount after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 7.

Participating Providers Outside the Wellmark Blue POS Network

The coinsurance for covered services is calculated on the lower of:

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
 - Deductible.
 - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage*,

Exclusions, and Limitations, page 41.

Often, the negotiated price will be a simple discount that reflects an actual price the local Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges.

Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Occasionally, claims for services you receive from a provider that participates with a Blue Cross and/or Blue Shield Plan outside of Iowa or South Dakota may need to be processed by Wellmark instead of by the BlueCard Program. In that case, coinsurance is calculated using the payment arrangement amount for covered services after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.

Laws in a small number of states may require the Host Blue Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Wellmark will calculate your payment obligation for any covered services according to applicable law. For more information, see *BlueCard Program*, page 49.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 7.

Provider Network

Under the medical benefits of this plan, your network of providers consists of domestic providers, Wellmark Blue POS and Participating providers. All other providers are not in your network.

Participating Providers

Participating Providers participate with a Blue Cross and/or Blue Shield Plan, but not with the Wellmark Blue POS network. When you receive services from Participating Providers:

- Wellmark Blue POS benefits apply if you have a Wellmark-approved referral.
- Out-of-network benefits apply if you do not have a Wellmark-approved referral.

Wellmark Blue POS Providers

Wellmark has a contracting relationship with these providers. When you receive services from a Wellmark Blue POS Provider:

- Level 1 Benefits apply when you receive covered services from a domestic provider.
- Level 2 Benefits apply when you receive covered services from a Network Provider that is not part of your employer's domestic provider network.
- The Wellmark Blue POS network payment obligation amounts may be waived or may be less than the Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 9.

Out-of-Network Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with Out-of-Network Providers, and they may not accept our

payment arrangements. Pharmacies other than those participating in the specialty pharmacy program that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. Therefore, when you receive services from Out-of-Network Providers:

- Out-of-network benefits apply. There may be exceptions to this rule for specific services. If so, these are described in the section *Details – Services Covered and Not Covered*.
- The following is true unless the No Surprises Act applies:
You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider will generally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from Out-of-Network Providers. See *Services Outside the Wellmark Blue POS Network*, page 49. However, when you receive services in an in-network facility and are provided covered services by an Out-of-Network ancillary provider, in-network cost-share will be applied and accumulate toward the out-of-pocket maximum. For this purpose, ancillary providers include pathologists, emergency room physicians, anesthesiologists, radiologists, or hospitalists. Because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you will still be

responsible for any difference between the billed charge and our settlement amount for the services from the Out-of-Network ancillary provider unless the No Surprises Act applies.

- Wellmark does not make claim payments directly to these providers, and you are responsible for ensuring that your provider is paid in full, unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you, and you are responsible for forwarding the check to the provider (plus any billed balance you may owe), unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- When the No Surprises Act applies to your items or services, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating

Provider who can furnish such item or service at such facility.

Amount Charged and Maximum Allowable Fee

Amount Charged

The amount charged is the amount a provider charges for a service or supply, regardless of whether the services or supplies are covered under your medical benefits.

Maximum Allowable Fee

The maximum allowable fee is the amount, established by Wellmark, using various methodologies, for covered services and supplies. Wellmark's amount paid may be based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee.

Payment Arrangements

Payment Arrangement Savings

Wellmark has contracting relationships with Wellmark Blue POS Providers. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

The savings from payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a Participating or Wellmark Blue POS provider. For the majority of services, the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or Wellmark Blue POS provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.

- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you may be responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 41.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
 - Deductible.
 - Coinsurance.
 - Copayment.
 - Amounts representing any general exclusions and conditions.
 - Network savings.

Payment Method for Services

When you receive a covered service or services that result in multiple claims, we will calculate your payment obligations based on the order in which we process the claims.

Provider Payment Arrangements

Provider payment arrangements are calculated using industry methods including, but not limited to, fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We

reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. Wellmark Blue POS and Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Capitation

Payment to healthcare providers for certain services is made according to a uniform amount per patient as determined by Wellmark Health Plan of Iowa, Inc.

Pharmacy Benefits Manager Fees and Drug Company Rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services to its

accounts, such as your group. Your group is to pay a monthly fee for such services.

Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark prescription drug coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group's use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to us by the pharmacy benefits manager unless your group's arrangement with us requires us to reduce such rebated amounts by the amount of any fees we paid to the pharmacy benefits manager for the services rendered to your group. We will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.

Prescription Drugs

Benefit Year

A benefit year is a period of 12 consecutive months beginning on August 1 or beginning on the day your coverage goes into effect. The benefit year starts over each August 1. Your benefit year continues even if your group sponsor changes Wellmark group health plan benefits during the year or you change to a different plan offering mid-benefit year from your same group sponsor.

Certain coverage changes result in your Wellmark identification number changing. In some cases, a new benefit year will start under the new ID number for the rest of the benefit year. In this case, the benefit year would be less than a full 12 months. In other cases (e.g., adding your spouse to your coverage) the benefit year would continue and not start over.

The benefit year is important for calculating:

- Out-of-pocket maximum.

Wellmark Blue Rx Value Plus Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Blue Rx Value Plus Drug List ("Drug List") contains drugs and pharmacy durable medical equipment devices physicians recognize as medically effective for a wide range of health conditions.

The Drug List is maintained with the assistance of practicing physicians, pharmacists, and Wellmark's pharmacy department.

To determine if a drug or pharmacy durable medical equipment device is covered, you or your physician must consult the Drug List. If a drug or pharmacy durable medical equipment device is not on the Drug List, it is not covered.

If you need help determining if a particular drug or pharmacy durable medical equipment device is on the Drug List, ask

your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Although only drugs and pharmacy durable medical equipment devices listed on the Drug List are covered, physicians are not limited to prescribing only the drugs on the list. Physicians may prescribe any medication, but only medications on the Drug List are covered. **Please note:** A medication or pharmacy durable medical equipment device on the Drug List will not be covered if the drug or pharmacy durable medical equipment device is specifically excluded under your Blue Rx Value Plus prescription drug benefits, or other limitations apply.

If a drug or pharmacy durable medical equipment device is not on the Wellmark Blue Rx Value Plus Drug List and you believe it should be covered, refer to *Exception Requests for Non-Formulary Prescription Drugs*, page 79.

The Wellmark Blue Rx Value Plus Drug List is subject to change.

Tiers

The Wellmark Blue Rx Value Plus Drug List also identifies which tier a drug is on:

Tier 1. Most generic drugs and some brand-name drugs that have no medically appropriate generic equivalent. Tier 1 drugs have the lowest payment obligation.

Tier 2. Drugs appear on this tier because they either have no medically appropriate generic equivalent or are considered less cost-effective than Tier 1 drugs. Tier 2 drugs have a higher payment obligation than Tier 1 drugs.

Tier 3. Drugs appear on this tier because they are less cost-effective than Tier 1 or Tier 2 drugs. Tier 3 drugs have the same payment obligation as Tier 2 drugs.

Pharmacy DME. Devices available on this tier include select durable medical equipment (DME) that are used in

conjunction with a drug and may be obtained from a pharmacy.

Generic and Brand Name Drugs

Generic Drug

Generic drug refers to an FDA-approved “A”-rated generic drug. This is a drug with active therapeutic ingredients chemically identical to its brand name drug counterpart.

Brand Name Drug

Brand name drug is a prescription drug patented by the original manufacturer. Usually, after the patent expires, other manufacturers may make FDA-approved generic copies.

Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, Wellmark’s pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

What You Pay

In most cases, when you purchase a brand name drug that has an FDA-approved “A”-rated medically appropriate generic equivalent, Wellmark will pay only what it would have paid for the medically appropriate equivalent generic drug. You will be responsible for your payment obligation for the medically appropriate equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not

be available in the amount prescribed by your physician.

In addition, coverage for certain drugs or pharmacy durable medical equipment devices is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs and pharmacy durable medical equipment devices with quantity limits, check with your pharmacist or physician or consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

Amount Charged and Maximum Allowable Fee

Amount Charged

The retail price charged by a pharmacy for a covered prescription drug or pharmacy durable medical equipment device.

Maximum Allowable Fee

The amount, established by Wellmark using various methodologies and data (such as the average wholesale price), payable for covered drugs and pharmacy durable medical equipment devices.

The maximum allowable fee may be less than the amount charged for the drug or pharmacy durable medical equipment device.

Participating vs. Nonparticipating Pharmacies

If you purchase a covered prescription drug or pharmacy durable medical equipment device at a nonparticipating pharmacy, you are responsible for the amount charged for the drug at the time you fill your prescription, and then you must file a claim.

Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug, less your copayment. The maximum allowable fee may be less than the amount you paid. In other words, you are responsible for any difference in cost

between what the pharmacy charges you for the drug and our reimbursement amount.

Your payment obligation for the purchase of a covered prescription drug or pharmacy durable medical equipment device at a participating pharmacy is the lesser of your copayment, the maximum allowable fee, or the amount charged for the drug.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Special Programs

We evaluate and monitor changes in the pharmaceutical industry in order to determine clinically effective and cost-effective coverage options. These evaluations may prompt us to offer programs that encourage the use of reasonable alternatives. For example, we may, at our discretion, temporarily waive your payment obligation on a qualifying prescription drug purchase.

Visit our website at *Wellmark.com* or call us to determine whether your prescription qualifies.

Savings and Rebates

Payment Arrangements

The benefits manager of this prescription drug program has established payment arrangements with participating pharmacies that may result in savings.

Pharmacy Benefits Manager Fees and Drug Company Rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services to its accounts, such as your group. Your group is to pay a monthly fee for such services.

Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark prescription drug

coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group's use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to us by the pharmacy benefits manager unless your group's arrangement with us requires us to reduce such rebated amounts by the amount of any fees we paid to the pharmacy benefits manager for the services rendered to your group. We will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.

8. Coverage Eligibility and Effective Date

Eligible Members

You are eligible for coverage if you meet your group sponsor's eligibility requirements. Your spouse or domestic partner may also be eligible for coverage if spouses or domestic partners are covered under this plan.

If a child is eligible for coverage under the group sponsor's eligibility requirements, the child must have one of the following relationships to the plan member or an enrolled spouse or domestic partner:

- A biological child.
- Legally adopted or placed for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child).
- A child for whom you have legal guardianship.
- A stepchild.
- A foster child.
- A biological child a court orders to be covered.

A child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

Please note: You must notify us or your group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your group sponsor or call the Customer Service number on your ID card.

In addition, a child must be one of the following:

- Under age 26.
- An unmarried full-time student enrolled in an accredited educational institution. Full-time student status continues during:

- Regularly-scheduled school vacations; and
 - Medically necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end.
- An unmarried child who is deemed disabled. The disability must have existed before the child turned age 26 or while the child was a full-time student. Wellmark considers a dependent disabled when he or she meets the following criteria:
 - Claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's, or retiree's tax return; and
 - Enrolled in and receiving Medicare benefits due to disability; or
 - Enrolled in and receiving Social Security benefits due to disability.

Documentation will be required.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 73.

When Coverage Begins

Coverage begins on the member's effective date. If you have just started a new job, or if a coverage enrollment event allows you to add a new member, ask your group sponsor about your effective date. Services received before the effective date of coverage are not eligible for benefits.

Changes to Information Related to You or to Your Benefits

Wellmark may, from time to time, permit changes to information relating to you or to your benefits. In such situations, Wellmark shall not be required to reprocess claims as a result of any such changes.

Qualified Medical Child Support Order

If you have a dependent child and you or your spouse's group sponsor receives a Medical Child Support Order recognizing the child's right to enroll in this group health plan or in your spouse's benefits plan, the group sponsor will promptly notify you or your spouse and the dependent that the order has been received. The group sponsor also will inform you or your spouse and the dependent of its procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

A QMCSO specifies information such as:

- Your name and last known mailing address.
- The name and mailing address of the dependent specified in the court order.
- A reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined.
- The period to which the order applies.

A Qualified Medical Child Support Order cannot require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

The order and the notice given by the group sponsor will provide additional information, including actions that you and the appropriate insurer must take to determine the dependent's eligibility and procedures for enrollment in the benefits plan, which must be done within specified time limits.

If eligible, the dependent will have the same coverage as you or your spouse and will be allowed to enroll immediately. You or your spouse's group sponsor will withhold any applicable share of the cost of the

dependent's health care coverage from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after we receive the QMCSO, your group sponsor must notify us when you become eligible for enrollment. Enrollment of the dependent will commence after you have satisfied the waiting period.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

Your group sponsor may not revoke enrollment or eliminate coverage for a dependent unless the group sponsor receives satisfactory written evidence that:

- The court or administrative order requiring coverage in a group health plan is no longer in effect;
- The dependent's eligibility for or enrollment in a comparable benefits plan that takes effect on or before the date the dependent's enrollment in this group health plan terminates; or
- The group sponsor eliminates dependent health coverage for all students/scholars.

The group sponsor is not required to maintain the dependent's coverage if:

- You or your spouse no longer pay the cost of coverage because the group sponsor no longer owes compensation; or
- You or your spouse have terminated your relationship with the group sponsor and have not elected to continue coverage.

9. Coverage Changes and Termination

Certain events may require or allow you to add or remove persons who are covered by this group health plan.

Coverage Change Events

Coverage Enrollment Events: The following events allow you or your eligible child to enroll for coverage. The following events may also allow your spouse or domestic partner to enroll for coverage if spouses or domestic partners are eligible for coverage under this plan. If your group sponsor offers more than one group health plan, the event also allows you to move from one plan option to another.

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA coverage.
- You or your eligible spouse or your dependent loses eligibility for creditable coverage or his or her group sponsor ceases contribution to creditable coverage.
- Spouse (if eligible for coverage) loses coverage through his or her employer.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

The following events allow you to add only the new dependent resulting from the event:

- Dependent child resumes status as a full-time student.
- Addition of a biological child by court order. See *Qualified Medical Child Support Order*, page 72.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

Coverage Removal Events: The following events require you to remove the affected family member from your coverage:

- Death.
- Divorce or annulment (if spouses are eligible for coverage under this plan). Legal separation, also, may result in removal from coverage. If you become legally separated, notify your group sponsor.
- Medicare eligibility. If you become eligible for Medicare, you must notify your group sponsor immediately. If you are eligible for this group health plan other than as a current student/scholar or a current student/scholar's spouse (if spouses are eligible for coverage under this plan), your Medicare eligibility may terminate this coverage.

In case of the following coverage removal events, the affected child's coverage may be continued until the end of the month on or after the date of the event:

- Completion of full-time schooling if the child is age 26 or older.
- Child who is not a full-time student or deemed disabled reaches age 26.
- Marriage of a child age 26 or older.

Reinstatement of Child

Reinstatement Events. A child up to age 26 who was removed from coverage may be reinstated on his or her parent's existing coverage under any of the following conditions:

- Involuntary loss of creditable coverage (including, but not limited to, group or *hawk-i* coverage).
- Loss of creditable coverage due to:
 - Termination of employment or eligibility.
 - Death of spouse.
 - Divorce.

- Court ordered coverage for spouse or minor children under the parent's health insurance.
- Exhaustion of COBRA or Iowa continuation coverage.
- The plan member is employed by an employer that offers multiple health plans and elects a different plan during an open enrollment period.
- A change in status in which the student/scholar becomes eligible to enroll in this group health plan and requests enrollment. See *Coverage Enrollment Events* earlier in this section.

Reinstatement Requirements. A request for reinstated coverage for a child up to age 26 must be made within 31 days of the reinstatement event. In addition, the following requirements must be met:

- The child must have been covered under the parent's current coverage at the time the child left that coverage to enroll in other creditable coverage.
- The parent's coverage must be currently in effect and continuously in effect during the time the child was enrolled in other creditable coverage.

Requirement to Notify Group Sponsor

You must notify your group sponsor of an event that changes the coverage status of members. Notify your group sponsor within 60 days in case of the following events:

- A birth, adoption, or placement for adoption.
- Divorce, legal separation, or annulment.
- Your dependent child loses eligibility for coverage.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

For all other events, you must notify your group sponsor within 31 days of the event.

If you do not provide timely notification of an event that requires you to remove an affected family member, your coverage may be terminated.

Coverage Termination

The following events terminate your coverage eligibility.

- You become unemployed when your eligibility is based on employment.
- You become ineligible under your group sponsor's eligibility requirements for reasons other than unemployment.
- Your group sponsor discontinues or replaces this group health plan.
- We decide to discontinue offering this group health benefit plan by giving written notice to you and your group sponsor and the Commissioner of Insurance at least 90 days prior to termination.
- We decide to nonrenew all group health benefit plans delivered or issued for delivery to group sponsors in Iowa by giving written notice to you and your group sponsor and the Commissioner of Insurance at least 180 days prior to termination.
- The number of individuals covered under this group health plan falls below the number or percentage of eligible individuals required to be covered.
- Your group sponsor sends a written request to terminate coverage.

Also see *Fraud or Intentional Misrepresentation of Material Facts*, and *Nonpayment* later in this section.

When you become unemployed and your eligibility is based on employment, your coverage will end at the end of the month your employment ends. When your coverage terminates for all other reasons, check with your group sponsor or call the Customer Service number on your ID card to verify the coverage termination date.

If you receive covered facility services as an inpatient of a hospital or a resident of a nursing facility on the date your coverage

eligibility terminates, payment for the covered facility services will end on the earliest of the following:

- The end of your remaining days of coverage under this benefits plan.
- The date you are discharged from the hospital or nursing facility following termination of your coverage eligibility.
- A period not more than 60 days from the date of termination.

Only facility services will be covered under this extension of benefits provision. Benefits for professional services will end on the date of termination of your coverage eligibility.

Fraud or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or intentionally misrepresent a material fact in your application; or
- Your group sponsor commits fraud or intentionally misrepresents a material fact under the terms of this group health plan.

If your coverage is terminated for fraud or intentional misrepresentation of a material fact, then:

- We may declare this group health plan void retroactively from the effective date of coverage following a 30-day written notice. In this case, we will recover any claim payments made.
- Premiums may be retroactively adjusted as if the fraud or intentionally misrepresented material fact had been accurately disclosed in your application.
- We will retain legal rights, including the right to bring a civil action.

Nonpayment

If you or your group sponsor fail to make required payments to us when due or within the allowed grace period, your coverage will terminate the last day of the month in which the required payments are due.

Coverage Continuation

Coverage Continuation or Reenrollment Upon Death of Eligible Peace Officer or Fire Fighter in the Line of Duty

Pursuant to Iowa Code Section 509A.13C, a governing body, county board of supervisors, or city council that sponsors a health care coverage plan for its employees under Iowa Code chapter 509A shall permit continuation of existing coverage or reenrollment in previously existing health coverage for the surviving spouse and each surviving child of an eligible peace officer or fire fighter. An “eligible peace officer or fire fighter” means a peace officer, as defined in Iowa Code Section 801.4, or a fire fighter, as defined in Iowa Code Section 411.1, to which a line of duty death benefit is payable pursuant to Iowa Code Section 97A.6, Subsection 16, Iowa Code Section 97B.52, Subsection 2, or Iowa Code Section 411.6, Subsection 15. A governing body, a county board of supervisors, or a city council shall also permit continuation of existing coverage for the surviving spouse and each surviving child of an eligible peace officer or fire fighter until such time as the determination is made as to whether to provide a line of duty death benefit.

Iowa Code Section 509A.13C applies retroactively to allow reenrollment in previously existing health coverage for the surviving spouse and each surviving child of an eligible peace officer or fire fighter who died in the line of duty on or after January 1, 1985. Coverage benefits will be provided for services on or after the date of reenrollment.

Eligibility for continuation and reenrollment are subject to any applicable conditions and limitations in Iowa Code Section 509A.13C. To request coverage continuation or reenrollment under Iowa Code Section 509A.13C, the surviving spouse, on his/her behalf and on behalf of each surviving child, must provide written notification to the applicable governing body, county board of supervisors, or city council. The governing body, county board

of supervisors, or city council must then notify Wellmark of the continuation or reenrollment request.

The governing body, county board of supervisors, or city council is not required to pay for the cost of the coverage for the surviving spouse and children but may choose to pay the cost or a portion of the cost for the coverage. If the full cost of the coverage is not paid by the governing body, county board of supervisors, or city council, the surviving spouse, on his/her behalf and on behalf of each surviving child, may elect to continue the health care coverage by paying that portion of the cost of the coverage not paid by the governing body, county board of supervisors, or city council.

The continuation and reenrollment options are not available if the surviving spouse or surviving child who would otherwise be entitled to continuation or reenrollment under this section was, through the surviving spouse's or surviving child's actions, a substantial contributing factor to the death of the eligible peace officer or fire fighter.

10. Claims

Once you receive services, we must receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which provider.

Neither you nor your provider shall bill Wellmark for services provided under a direct primary care agreement as authorized under Iowa law.

When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. Participating and Wellmark Blue POS providers file claims for you.
- Purchase prescription drugs from a nonparticipating pharmacy.
- Purchase prescription drugs from a participating pharmacy but do not present your ID card.
- Pay in full for a drug that you believe should have been covered.

Your submission of a prescription to a participating pharmacy is not a filed claim and therefore is not subject to appeal procedures as described in the *Appeals* section. However, you may file a claim with us for a prescription drug purchase you think should have been a covered benefit.

Wellmark must receive claims within 180 days following the date of service of the claim (or 180 days from date of discharge for inpatient claims) or if you have other coverage that has primary responsibility for payment then within 180 days of the date of the other carrier's explanation of benefits. If you receive services outside of Wellmark's service area, Wellmark must receive the claim within 180 days following the date of service (or 180 days from date of discharge for inpatient claims) or within the filing requirement in the contractual agreement between the Participating Provider and the Host Blue. If you receive services from an Out-of-Network Provider, the claim has to

be filed within 180 days following the date of service or date of discharge for inpatient claims.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

Forms are available at *Wellmark.com* or by calling the Customer Service number on your ID card or from your personnel department.

2. Fill Out the Claim Form

Follow the same claim filing procedure regardless of where you received services. Directions are printed on the back of the claim form. Complete all sections of the claim form. For more efficient processing, all claims (including those completed out-of-country) should be written in English.

If you need assistance completing the claim form, call the Customer Service number on your ID card.

Medical Claim Form. Follow these steps to complete a medical claim form:

- Use a separate claim form for each covered family member and each provider.
- Attach a copy of an itemized statement prepared by your provider. We cannot accept statements you prepare, cash register receipts, receipt of payment notices, or balance due notices. In order for a claim request to qualify for processing, the itemized statement must be on the provider's stationery, and include at least the following:
 - Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
 - Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.

- Date(s) of service.
- Charge for each service.
- Place of service (office, hospital, etc.).
- For injury or illness: date and diagnosis.
- For inpatient claims: admission date, patient status, attending physician ID.
- Days or units of service.
- Revenue, diagnosis, and procedure codes.
- Description of each service.

Prescription Drugs Covered Under Your Medical Benefits Claim Form.

For prescription drugs covered under your medical benefits (not covered under your Blue Rx Value Plus prescription drug benefits), use a separate prescription drug claim form and include the following information:

- Pharmacy name and address.
- Patient information: first and last name, date of birth, gender, and relationship to plan member.
- Date(s) of service.
- Description and quantity of drug.
- Original pharmacy receipt or cash receipt with the pharmacist’s signature on it.

Blue Rx Value Plus Prescription Drug Claim Form. For prescription drugs covered under your Blue Rx Value Plus prescription drug benefits, complete the following steps:

- Use a separate claim form for each covered family member and each pharmacy.
- Complete all sections of the claim form. Include your daytime telephone number.
- Submit up to three prescriptions for the same family member and the same pharmacy on a single claim form. Use additional claim forms for claims that exceed three prescriptions or if the

prescriptions are for more than one family member or pharmacy.

- Attach receipts to the back of the claim form in the space provided.

3. Sign the Claim Form

4. Submit the Claim

We recommend you retain a copy for your records. The original form you send or any attachments sent with the form cannot be returned to you.

Medical Claims and Claims for Drugs Covered Under Your Medical Benefits. Send the claim to:

Wellmark
 Station 1E238
 P.O. Box 9291
 Des Moines, IA 50306-9291

Medical Claims for Services Received Outside the United States. Send the claim to the address printed on the claim form.

Blue Rx Value Plus Prescription Drug Claims. Send the claim to the address printed on the claim form.

We may require additional information from you or your provider before a claim can be considered complete and ready for processing.

Notification of Decision

You will receive an Explanation of Benefits (EOB) following your claim. The EOB is a statement outlining how we applied benefits to a submitted claim. It details amounts that providers charged, network savings, our paid amounts, and amounts for which you are responsible.

In case of an adverse decision, the notice will be sent within 30 days of receipt of the claim. We may extend this time by up to 15 days if the claim determination is delayed for reasons beyond our control. If we do not send an explanation of benefits statement or a notice of extension within the 30-day period, you have the right to begin an appeal. We will notify you of the

circumstances requiring an extension and the date by which we expect to render a decision.

If an extension is necessary because we require additional information from you, the notice will describe the specific information needed. You have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied.

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 81.

Once we pay your claim, whether our payment is sent to you or to your provider, our obligation to pay benefits for the claim is discharged. However, we may adjust a claim due to overpayment or underpayment. In the case of Out-of-Network hospitals, M.D.s, and D.O.s located in Iowa, the health plan payment is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider, plus any difference between the amount charged and our payment.

Exception Requests for Non-Formulary Prescription Drugs

Prescription drugs that are not listed on the Wellmark Blue Rx Value Plus Drug List are not covered. However, you may submit an exception request for coverage of a non-formulary drug (i.e., a drug that is not included on the Wellmark Blue Rx Value Plus Drug List). The form is available at *Wellmark.com* or by calling the Customer Service number on your ID card. Your prescribing physician or other provider must provide a clinical justification supporting the need for the non-formulary drug to treat your condition. The provider should include a statement that:

- All covered formulary drugs on any tier have been ineffective; or

- All covered formulary drugs on any tier will be ineffective; or
- All covered formulary drugs on any tier would not be as effective as the non-formulary drug; or
- All covered formulary drugs would have adverse effects.

Wellmark will respond within 72 hours of receiving the Exception Request for Non-Formulary Prescription Drugs form. For expedited requests, Wellmark will respond within 24 hours.

In the event Wellmark denies your exception request, you and your provider will be sent additional information regarding your ability to request an independent review of our decision. If the independent reviewer approves your exception request, we will treat the drug as a covered benefit for the duration of your prescription. You will be responsible for out-of-pocket costs (for example: deductible, copay, or coinsurance, if applicable) as if the non-formulary drug is on the highest tier of the Wellmark Blue Rx Value Plus Drug List. Amounts you pay will be counted toward any applicable out-of-pocket maximums. If the independent reviewer upholds Wellmark's denial of your exception request, the drug will not be covered, and this decision will not be considered an adverse benefit determination, and will not be eligible for further appeals. You may choose to purchase the drug at your own expense.

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that are not on the Wellmark Blue Rx Value Plus Drug List. It is not available for items that are specifically excluded under your benefits, such as cosmetic drugs, convenience packaging, non-FDA approved drugs, drugs not approved to be covered by Wellmark's P&T Committee, infused drugs, most over-the-counter medications, nutritional, vitamin and dietary supplements, or antigen therapy. The preceding list of excluded items is

illustrative only and is not a complete list of items that are not eligible for the process.

Request for Benefit Exception Review

If you have received an adverse benefit determination that denies or reduces benefits or fails to provide payment in whole or in part for any of the following services, when recommended by your treating provider as medically necessary, you or an individual acting as your authorized representative may request a benefit exception review.

Services subject to this exception process:

- For a woman who previously has had breast cancer, ovarian cancer, or other cancer, but who has not been diagnosed with BRCA-related cancer, appropriate preventive screening, genetic counseling, and genetic testing.
- FDA-approved or FDA-cleared contraceptive items or services prescribed by your health care provider based upon a specific determination of medical necessity for you.
- For transgender individuals, sex-specific preventive care services (e.g., mammograms and Pap smears) that your attending provider has determined are medically appropriate.
- For dependent children, certain well-woman preventive care services that the attending provider determined are age- and developmentally-appropriate.
- Anesthesia services in connection with a preventive colonoscopy when your attending provider determined that anesthesia would be medically appropriate.
- A required consultation prior to a screening colonoscopy, if your attending provider determined that the pre-procedure consultation would be medically appropriate for you.
- If you received pathology services from an in-network provider related to a preventive colonoscopy screening for which you were responsible for a portion of the cost, such as a deductible, copayment or coinsurance.
- Certain immunizations that ACIP recommends for specified individuals (rather than for routine use for an entire population), when prescribed by your health care provider consistent with the ACIP recommendations.
- FDA-approved intrauterine devices and implants, if prescribed by your health care provider.
- Brand name drug when the generic equivalent drug is available, if your provider determines the brand name drug is medically necessary and the generic equivalent drug is medically inappropriate.

You may request a benefit exception review orally or in writing by submitting your request to the address listed in the *Appeals* section. To be considered, your request must include supporting medical record documentation and a letter or statement from your treating provider that the services or supplies were medically necessary and your treating provider's reason(s) for their determination that the services or supplies were medically necessary.

Your request will be addressed within the timeframes outlined in the *Appeals* section based upon whether your request is a medically urgent or non-medically urgent matter.

11. Coordination of Benefits

Coordination of benefits applies when you have more than one plan, insurance policy, or group health plan that provides the same or similar benefits as this plan. Benefits payable under this plan, when combined with those paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount.

The method we use to calculate the payment arrangement amount may be different from your other plan's method.

In some instances, our claim payment amount is based on a uniform payment per patient, called *capitation*. When you receive services payable by capitation and your other carrier has primary payment responsibility for covered services:

- We are not responsible for payment to your health care provider beyond the applicable capitation amount; and
- You are not responsible for copayment amounts that would apply if coverage under this medical benefits plan were the primary coverage.

Other Coverage

When you receive services, you must inform us that you have other coverage, and inform your health care provider about your other coverage. Other coverage includes any of the following:

- Group and nongroup insurance contracts and subscriber contracts.
- HMO contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term contracts, such as skilled nursing care.

- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

Coverage that is not subject to coordination of benefits includes the following:

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for nonmedical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

You must cooperate with Wellmark and provide requested information about other coverage. Failure to provide information can result in a denied claim. We may get the facts we need from or give them to other organizations or persons for the purpose of applying the following rules and determining the benefits payable under this plan and other plans covering you. We need not tell, or get the consent of, any person to do this.

Your Wellmark Blue POS Provider will forward your coverage information to us. If you see an Out-of-Network Provider, you are responsible for informing us about your other coverage.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services or obtain a covered prescription drug, a claim should be submitted to your other insurance carrier

first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 180 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

We follow certain rules to determine which health plan or coverage pays first (as the primary plan) when other coverage provides the same or similar benefits as this group health plan. Here are some of those rules:

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide Out-of-Network benefits.)

The following rules are to be applied in order. The first rule that applies to your situation is used to determine the primary plan.

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of

federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed, so that the plan covering the person as the student/scholar, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.

- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Notwithstanding the preceding rules, when you present your Blue Rx Value Plus ID card to a pharmacy as the primary payer, your Blue Rx Value Plus prescription drug benefits are primary for prescription drugs purchased at the pharmacy. If, under the preceding rules, your Blue Rx Value Plus prescription drug benefits are secondary and you present your Blue Rx Value Plus ID card to a pharmacy as the secondary payer, your Blue Rx Value Plus prescription drug benefits are secondary for prescription drugs purchased at the pharmacy.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Dependent Children

To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday

occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
 - If a court decree states that one of the parents is responsible for the child’s health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent’s coverage pays first. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - If a court decree states that both parents are responsible for the child’s health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree

or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this *Dependent Children* section.
- For a dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child’s coverage under the spouse’s plan began on the same date as the dependent child’s coverage under either or both parents’ plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of this *Dependent Children* section, to the dependent child’s parent or parents and the dependent’s spouse.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

If you have coverage with another plan that is excess or always secondary or that does not comply with the preceding rules of coordination, we may coordinate benefits on the following basis:

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits

will be determined as if this plan were secondary. Our payment will be limited to the amount we would have paid had this plan been primary.

- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 98.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Effects on the Benefits of this Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, total benefits paid or provided by all plans for the claim do not exceed the

total allowable expense for that claim. In addition, the secondary plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

If a person is enrolled in two or more closed panel plans and if, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right of Recovery

If the amount of payments made by us is more than we should have paid under these coordination of benefits provisions, we may recover the excess from any of the persons to or for whom we paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

Plans That Provide Benefits as Services

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the service from the primary plan, to the extent benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations.

The following provisions apply only if you have both Medicare and group health coverage and meet the specific Medicare Secondary Payer provisions for the applicable Medicare entitlement reason.

Medicare Part B Drugs

Drugs paid under Medicare Part B are covered under the medical benefits of this plan.

Working Aged

If you are a member of a group health plan of a group sponsor with at least 20 students/scholars for each working day for at least 20 calendar weeks in the current or preceding year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current student/scholar or spouse of a current student/scholar covered by a group health plan.

Working Disabled

If you are a member of a group health plan of a group sponsor with at least 100 full-time, part-time, or leased employees on at least 50 percent of regular business days during the preceding calendar year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by a group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all group sponsors, regardless of the number of employees. Under these requirements, Medicare is the secondary payer during the first 30 months of Medicare eligibility if both of the following are true:

- The beneficiary is eligible for Medicare coverage as an ESRD patient; and
- The beneficiary is covered by a group health plan.

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary

becomes eligible for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws. For complete information, contact your group sponsor or the Social Security Administration.

12. Appeals

Right of Appeal

You have the right to one full and fair review in the case of an adverse benefit determination, including a determination on a surprise bill, that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim, a rescission of coverage, or an adverse benefit determination concerning a pre-service notification requirement. Pre-service notification requirements are:

- A precertification request.
- A notification of admission or services.
- A prior approval request.
- A prior authorization request for prescription drugs.

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *Wellmark.com*. See *Authorized Representative*, page 95.

Medically Urgent Appeal

To appeal an adverse benefit determination involving a medically urgent situation, you may request an expedited appeal, either orally or in writing. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision.

Non-Medically Urgent Appeal

To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

What to Include in Your Internal Appeal

You must submit all relevant information with your appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

For a prescription drug appeal, you also must submit:

- Name and phone number of the pharmacy.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

If you have difficulty obtaining this information, ask your provider or pharmacist to assist you.

Where to Send Internal Appeal

Wellmark Health Plan of Iowa, Inc.
Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232

Review of Internal Appeal

Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or not the information was presented or

available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you prior to Wellmark issuing a final adverse benefit determination and you will have the opportunity to respond to that information or to provide information.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, we will consult an appropriate medical expert who was not previously involved in the original decision and who has no conflict of interest in making the decision. If we deny your appeal, in whole or in part, you may request, in writing, the identity of the medical expert we consulted.

Decision on Internal Appeal

The decision on appeal is the final internal determination. Once a decision on internal appeal is reached, your right to internal appeal is exhausted.

Medically Urgent Appeal

For a medically urgent appeal, you will be notified (by telephone, e-mail, fax or another prompt method) of our decision as soon as possible, based on the medical situation, but no later than 72 hours after your expedited appeal request is received. If the decision is adverse, a written notification will be sent.

All Other Appeals

For all other appeals, you will be notified in writing of our decision. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days.

External Review

You have the right to request an external review of a final adverse determination

involving a covered service when the determination involved:

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- A surprise bill.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 57.
- A rescission of coverage.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under this plan.

The external review will be conducted by independent health care professionals who have no association with us and who have no conflict of interest with respect to the benefit determination.

Have you exhausted the appeal process?

Before you can request an external review, you must first exhaust the internal appeal process described earlier in this section. However, if you have not received a decision regarding the adverse benefit determination within 30 days following the date of your request for an appeal, you are considered to have exhausted the internal appeal process.

Requesting an external review. You or your authorized representative may request an external review through the Iowa Insurance Division by completing an External Review Request Form and submitting the form as described in this section. You may obtain this request form by calling the Customer Service number on your ID card, by visiting our website at *Wellmark.com*, by contacting the Iowa Insurance Division, or by visiting the Iowa Insurance Division's website at www.iid.iowa.gov.

You will be required to authorize the release of any medical records that may be required

to be reviewed for the purpose of reaching a decision on your request for external review.

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

Iowa Insurance Division
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
Fax: 515-654-6500
E-mail:
iid.marketregulation@iid.iowa.gov

How the review works. Upon notification that an external review request has been filed, Wellmark will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, the Iowa Insurance Division will decide whether your request is eligible for an external review, and if it is, the Iowa Insurance Division will assign an independent review organization (IRO) to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date the Iowa Insurance Division receives your request for an external review.

Need help? You may contact the Iowa Insurance Division at **877-955-1212** at any time for assistance with the external review process.

Expedited External Review

You do not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if you have a medical condition for which the time frame for completing an internal appeal or for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

You may also have the right to request an expedited external review of a final adverse

determination that concerns an admission, availability of care, concurrent review, or service for which you received emergency services, and you have not been discharged from a facility.

If our adverse benefit determination is that the service or treatment is investigational or experimental and your treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, you may also have the right to request an expedited external review.

You or your authorized representative may submit an oral or written expedited external review request to the Iowa Insurance Division by contacting the Iowa Insurance Division at **877-955-1212**.

If the Insurance Division determines the request is eligible for an expedited external review, the Division will immediately assign an IRO to conduct the review and a decision will be made expeditiously, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

Arbitration and Legal Action

You shall not start arbitration or legal action against us until you have exhausted the appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 97, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

13. Arbitration and Legal Action

PLEASE READ THIS SECTION CAREFULLY

Mandatory Arbitration

You shall not start an action against us on any Claims (as defined below) unless you have first exhausted the appeal processes described in the *Appeals* section of this coverage manual.

Except as solely discussed below, this section provides that Claims must be resolved by binding mandatory arbitration. Arbitration replaces the right to go to court, have a jury trial or initiate or participate in a class action. In arbitration, disputes are resolved by an arbitrator, not a judge or a jury. Arbitration procedures are simpler and more limited than in court.

Covered Claims

Except as solely stated below, you or we must arbitrate any claim, dispute or controversy arising out of or related to this coverage manual or any other document related to your health plan, including, but not limited to, member eligibility, benefits under your health plan or administration of your health plan (any and/or all of the foregoing called "Claims").

Except as stated below, all Claims are subject to mandatory arbitration, no matter what legal theory they are based, whether in law or equity, upon or what remedy (damages, or injunctive or declaratory relief) they seek, including Claims based on contract, tort (including intentional tort), fraud, agency, your or our negligence, statutory or regulatory provisions, or any other sources of law; counterclaims, cross-claims, third-party claims, interpleaders or otherwise; Claims made regarding past, present or future conduct; and Claims made independently or with other claims. This also includes Claims made by or against anyone connected with us or you or claiming through us or you, or by someone

making a claim through us or you, such as a covered family member, employee, agent, representative, or an affiliated or subsidiary company. For purposes of this *Arbitration and Legal Action* section, the words "we," "us," and "our" refer to Wellmark, Inc., and its subsidiaries and affiliates, the plan sponsor and/or the plan administrator, as well as their respective directors, officers, employees and agents.

No Class Arbitrations and Class Actions Waiver

YOU UNDERSTAND AND AGREE THAT YOU AND WE BOTH ARE VOLUNTARILY AND IRREVOCABLY WAIVING THE RIGHT TO PURSUE OR HAVE A DISPUTE RESOLVED AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS, COLLECTIVE OR REPRESENTATIVE PROCEEDING PENDING BETWEEN YOU AND US. YOU ARE AGREEING TO GIVE UP THE ABILITY TO PARTICIPATE IN CLASS ARBITRATIONS, CLASS ACTIONS AND ANY OTHER COLLECTIVE OR REPRESENTATIVE ACTIONS. Neither you nor we consent to the incorporation of the AAA Supplementary Rules for Class Arbitration into the rules governing the arbitration of Claims. The arbitrator has no authority to arbitrate any claim on a class or representative basis and may award relief only on an individual basis. Claims of two or more persons may not be combined in the same arbitration, unless both you and we agree to do so.

Claims Excluded from Mandatory Arbitration

- Small Claims – individual Claims filed in a small claims court are not subject to arbitration, as long as the matter stays in small claims court.
- Claims Excluded By Applicable Law – federal or state law may exempt certain Claims from mandatory arbitration. **IF**

AN ARBITRATOR DETERMINES A PARTICULAR CLAIM IS EXCLUDED FROM ARBITRATION BY FEDERAL OR STATE LAW, CLAIMS EXCLUDED BY APPLICABLE LAW, LATER IN THIS SECTION, AND GOVERNING LAW, PAGE 97, WILL APPLY TO THE PARTIES AND SUCH PARTICULAR CLAIM.

Arbitration Process Generally

- No demand for arbitration of a Claim because of a health benefit claim under this plan, or because of the alleged breach of this plan, shall be made more than two years after the end of the calendar year in which the services or supplies were provided.
- Arbitration shall be conducted by the American Arbitration Association (“AAA”) according to the Federal Arbitration Act (“FAA”) (to the exclusion of any state laws inconsistent therewith), this arbitration provision and the applicable AAA Consumer Arbitration Rules in effect when the Claim is filed (“AAA Rules”), except where those rules conflict with this arbitration provision. You can obtain copies of the AAA Rules at the AAA’s website (www.adr.org). You or we may choose to have a hearing, appear at any hearing by phone or other electronic means, and/or be represented by counsel. Any in-person hearing will be held in the same city as the U.S. District Court closest to your billing address.
- Either you or we may apply to a court for emergency, temporary or preliminary injunctive relief or an order in aid of arbitration (i) prior to the appointment of an arbitrator or (ii) after the arbitrator makes a final award and closes the arbitration. Once an arbitrator has been appointed until the arbitration is closed, emergency, temporary or preliminary injunctive relief may only be granted by the arbitrator. Either you or we may apply to a court for enforcement of any emergency, temporary or preliminary injunctive relief granted by the arbitrator.
- Arbitration may be compelled at any time by either party, even where there is a pending lawsuit in court, unless a trial has begun or a final judgment has been entered. Neither you nor we waive the right to arbitrate by filing or serving a complaint, answer, counterclaim, motion, or discovery in a court lawsuit. To invoke arbitration, a party may file a motion to compel arbitration in a pending matter and/or commence arbitration by submitting the required AAA forms and requisite filing fees to the AAA.
- The arbitration shall be conducted by a single arbitrator in accordance with this arbitration provision and the AAA Rules, which may limit discovery. The arbitrator shall not apply any federal or state rules of civil procedure for discovery, but the arbitrator shall honor claims of privilege recognized at law and shall take reasonable steps to protect plan information and other confidential information of either party if requested to do so. The parties agree that the scope of discovery will be limited to non-privileged information that is relevant to the Claim, and consistent with the parties’ intent, the arbitrator shall ensure that allowed discovery is reasonable in scope, cost-effective and non-onerous to either party. The arbitrator shall apply the FAA and other applicable substantive law not inconsistent with the FAA, and may award damages or other relief under applicable law.
- The arbitrator shall make any award in writing and, if requested by you or us, may provide a brief written statement of the reasons for the award. An arbitration award shall decide the rights and obligations only of the parties named in the arbitration and shall not have any bearing on any other person or dispute.

IF ARBITRATION IS INVOKED BY ANY PARTY WITH RESPECT TO A CLAIM, NEITHER YOU NOR WE WILL HAVE THE RIGHT TO LITIGATE THAT CLAIM IN COURT OR HAVE A JURY TRIAL ON THAT CLAIM, OR TO ENGAGE IN PREARBITRATION DISCOVERY EXCEPT AS PROVIDED FOR IN THE APPLICABLE ARBITRATION RULES. THE ARBITRATOR'S DECISION WILL BE FINAL AND BINDING. YOU UNDERSTAND THAT OTHER RIGHTS THAT YOU WOULD HAVE IF YOU WENT TO COURT MAY ALSO NOT BE AVAILABLE IN ARBITRATION.

Arbitration Fees and Other Costs

The AAA Rules determine what costs you and we will pay to the AAA in connection with the arbitration process. In most instances, your responsibility for filing, administrative and arbitrator fees to pursue a Claim in arbitration will not exceed \$200. However, if the arbitrator decides that either the substance of your claim or the remedy you asked for is frivolous or brought for an improper purpose, the arbitrator will use the AAA Rules to determine whether you or we are responsible for the filing, administrative and arbitrator fees.

You may wish to consult with or be represented by an attorney during the arbitration process. Each party is responsible for its own attorney's fees and other expenses, such as witness fees and expert witness costs.

Confidentiality

The arbitration proceedings and arbitration award shall be maintained by the parties as strictly confidential, except as is otherwise required by court order, as is necessary to confirm, vacate or enforce the award, and for disclosure in confidence to the parties' respective attorneys and tax advisors of a party who is an individual.

Questions of Arbitrability

You and we mutually agree that the arbitrator, and not a court, will decide in the first instance all questions of substantive arbitrability, including without limitation the validity of this Section, whether you and we are bound by it, and whether this Section applies to a particular Claim.

Claims Excluded By Applicable Law

If an arbitrator determines a particular Claim is excluded from arbitration by federal or state law, you and we agree that the following terms will apply to any legal or equitable action brought in court because of such Claim:

- You shall not bring any legal or equitable action against us because of a health benefit claim under this plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in which the services or supplies were provided.
- Any action brought because of a Claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.
- **YOU AND WE BOTH WAIVE ANY RIGHT TO A JURY TRIAL WITH RESPECT TO AND IN ANY CLAIM.**
- **FURTHER, YOU AND WE BOTH WAIVE ANY RIGHT TO SEEK OR RECOVER PUNITIVE OR EXEMPLARY DAMAGES WITH RESPECT TO ANY CLAIM.**

Survival and Severability of Terms

This *Arbitration and Legal Action* section will survive termination of the plan. If any portion of this provision is deemed invalid or unenforceable under any law or statute it will not invalidate the remaining portions of this *Arbitration and Legal Action* section or the plan. To the extent a Claim qualifies for mandatory arbitration and there is a conflict or inconsistency between the AAA Rules

and this *Arbitration and Legal Action*
section, this *Arbitration and Legal Action*
section will govern.

14. General Provisions

Contract

The conditions of your coverage are defined in your contract. Your contract includes:

- Any application you submitted to us or to your group sponsor.
- Any agreement or group policy we have with your group sponsor.
- Any application completed by your group sponsor.
- This coverage manual and any amendments.

All of the statements made by you or your group sponsor in any of these materials will be treated by us as representations, not warranties.

Interpreting this Coverage Manual

We will interpret the provisions of this coverage manual and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this coverage manual. If any benefit described in this coverage manual is subject to a determination of medical necessity, unless otherwise required by law, we will make that factual determination. Our interpretations and determinations are final and conclusive, subject to the appeal procedures outlined earlier in this coverage manual.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your coverage manual. You should become familiar with the entire document.

Plan Year

The Plan Year has been designated and communicated to Wellmark by your group health plan's plan sponsor or plan

administrator as the twelve month period commencing on the effective date of your group health plan's annual renewal with Wellmark.

Authority to Terminate, Amend, or Modify

Your group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage manual at any time. Any amendment or modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

Authorized Group Benefits Plan Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions described in this coverage manual. This coverage manual cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 73.

Member Participation

Information will be made available to members regarding matters such as wellness, general health education, and matters of policy and operation of Wellmark Health Plan of Iowa, Inc.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized

Representative Form. This form is available at *Wellmark.com* or by calling the Customer Service number on your ID card.

In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form.

An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You may authorize only one person as your representative at a time. You may revoke the authorized representative at any time.

Release of Information

By enrolling in this group health plan, you have agreed to release any necessary information requested about you so we can process claims for benefits.

You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts when providing information, then we may terminate your coverage under this group health plan.

Privacy of Information

Your group sponsor is required to protect the privacy of your health information. It is required to request, use, or disclose your health information only as permitted or required by law. For example, your group sponsor has contracted with Wellmark to administer this group health plan and Wellmark will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

Treatment

We may disclose your health information to a physician or other health care provider in order for such health care provider to provide treatment to you.

Payment

We may use and disclose your health information to pay for covered services from physicians, hospitals, and other providers, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from your group sponsor, to issue explanations of benefits to the person enrolled in the group health plan in which you participate, and the like. We may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

Health Care Operations

We may use and disclose your health information in connection with health care operations. Health care operations include, but are not limited to, determining payment and rates for your group health plan; quality assessment and improvement activities; reviewing the competence or qualifications of health care practitioners, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities; medical review, legal services, and auditing, including fraud and abuse detection and compliance; business planning and development; and business management and general administrative activities.

Other Disclosures

Your group sponsor or Wellmark is required to obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person. If you give us an authorization, you may revoke it in writing

at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Member Health Support Services

Wellmark may from time to time make available to you certain health support services (such as disease management), for a fee or for no fee. Wellmark may offer financial and other incentives to you to use such services. As a part of the provision of these services, Wellmark may:

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health support service vendors, for purposes of providing such services to you.

Wellmark will use and disclose information according to the terms of our Privacy Practices Notice, which is available upon request or at *Wellmark.com*.

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. These value added or innovative benefits are not insurance and may be changed or eliminated at any time. Examples include Blue365®, identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Value-Based Programs

Value-based programs involve local health care organizations that are held accountable for the quality and cost of care delivered to a defined population. Value-based programs can include accountable care organizations (ACOs), patient centered medical homes (PCMHs), and other programs developed by Wellmark, the Blue Cross Blue Shield Association, or other Blue Cross Blue Shield health plans ("Blue Plans"). Wellmark and Blue Plans have entered into collaborative arrangements with value-based programs under which the health care providers participating in them are eligible for financial incentives relating to quality and cost-effective care of Wellmark and/or Blue Plan members. If your physician, hospital, or other health care provider participates in the Wellmark ACO program or other value-based program, Wellmark may make available to such health care providers your health care information, including claims information, for purposes of helping support their delivery of health care services to you.

Nonassignment

Except as required by law, benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Whether made before or after services are provided, you are prohibited from assigning any claim. You are further prohibited from assigning any cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan, even if assignment includes the provider's rights to receive payment, will be null and void. Nothing contained in this group health plan shall be construed to make the health plan or Wellmark liable to any third party to whom a member may be liable for medical care, treatment, or services.

Governing Law

To the extent not superseded by the laws of the United States, the group health plan will

be construed in accordance with and governed by the laws of the state of Iowa.

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

This group health plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and Wellmark has a legal obligation to provide benefits for those services, Wellmark will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Medicaid Reimbursement

When a Wellmark Blue POS Provider submits a claim to a state Medicaid program for a covered service and Wellmark reimburses the state Medicaid program for the service, Wellmark's total payment for the service will be limited to the amount paid to the state Medicaid program. No additional payments will be made to the provider or to you.

Subrogation

For purposes of this "Subrogation" section, "third party" includes, but is not limited to, any of the following:

- The responsible person or that person's insurer;
- Uninsured motorist coverage;

- Underinsured motorist coverage;
- Personal umbrella coverage;
- Other insurance coverage including, but not limited to, homeowner's, motor vehicle, or medical payments insurance; and
- Any other payment from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

Right of Subrogation

If you or your legal representative have a claim to recover money from a third party and this claim relates to an illness or injury for which this group health plan provides benefits, we, on behalf of your group sponsor, will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

Right of Reimbursement

If you have an illness or injury as a result of the act of a third party or arising out of obligations you have under a contract and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse us for all benefits paid for the illness or injury from money received from the third party or its insurer, or under the contract, to the extent of the amount paid by this group health plan on the claim.

Once you receive benefits under this group health plan arising from an illness or injury, we will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any third party.

You agree to recognize our rights under this group health plan to subrogation and reimbursement. These rights provide us with a priority over any money paid by a third party to you relative to the amount paid by this group health plan, including priority over any claim for nonmedical charges, or other costs and expenses. We will assume all rights of recovery, to the

extent of payment made under this group health plan, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement

You or your legal representative must do whatever we request with respect to the exercise of our subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform us in writing if you have an illness or injury caused by a third party or arising out of obligations you have under a contract. You or your legal representative must provide the following information, by registered mail, as soon as reasonably practicable of such illness or injury to us as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;

- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by us.

Send this information to:

Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue, Station 5W580
Des Moines, IA 50309-2901

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.
- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid under this group health plan in connection with the illness or injury) in trust for the benefit of this group health plan as trustee(s) for us until the extent of our right to reimbursement or subrogation has been resolved.
- In the event you invoke your rights of recovery against a third-party related to

the illness or injury, you will not seek an advancement of costs or fees from us.

- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses, and the “make whole” rule is specifically rejected and inapplicable under this group health plan.
- We will not be liable for payment of any share of attorneys’ fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing, and the “common fund” rule is specifically rejected and inapplicable under this group health plan.

It is further agreed that in the event that you fail to take the necessary legal action to recover from the responsible party, we shall have the option to do so and may proceed in its name or your name against the responsible party and shall be entitled to the recovery of the amount of benefits paid under this group health plan and shall be entitled to recover its expenses, including reasonable attorney fees and costs, incurred for such recovery.

In the event we deem it necessary to institute legal action against you if you fail to repay us as required in this group health plan, you shall be liable for the amount of such payments made by us as well as all of our costs of collection, including reasonable attorney fees and costs.

You hereby authorize the deduction of any excess benefit received or benefits that should not have been paid, from any present or future compensation payments.

You and your covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

Our right of subrogation and reimbursement under this group health plan applies to all rights of recovery, and not

only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and reimbursement if there is any recovery on your claim.

We reserve the right to offset any amounts owed to us against any future claim payments.

Workers’ Compensation

If you have received benefits under this group health plan for an injury or condition that is the subject or basis of a workers’ compensation claim (whether litigated or not), we are entitled to reimbursement to the extent benefits are paid under this plan in the event that your claim is accepted or adjudged to be covered under workers’ compensation.

Furthermore, we are entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers’ compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. We will not be liable for any attorney’s fees or other expenses incurred in obtaining any proceeds for any workers’ compensation claim.

We utilize industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. We reserve the right to seek reimbursement of any such claim or to waive reimbursement of any claim, at our discretion.

Payment in Error

If for any reason we make payment in error, we may recover the amount we paid.

If we determine we did not make full payment, Wellmark will make the correct payment without interest.

Notice

If a specific address has not been provided elsewhere in this coverage manual, you may send any notice to Wellmark's home office:

Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue
Des Moines, IA 50309-2901

Any notice from Wellmark to you is acceptable when sent to your address as it appears on Wellmark's records or the address of the group through which you are enrolled.

Inspection of Coverage

Except for groups that maintain a cafeteria plan pursuant to Section 125 of the Internal Revenue Code (26 USCA § 125), a member may, if evidence of coverage is not satisfactory for any reason, return the evidence of coverage within 10 days of its receipt and receive full refund of the deposit paid, if any. This right will not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the member utilizes the services of the HMO within the 10-day period. Members in cafeteria plans must adhere to the plan provisions concerning termination or changes in coverage.

Submitting a Complaint

If you are dissatisfied or have a complaint regarding our products or services, call the Customer Service number on your ID card. We will attempt to resolve the issue in a timely manner. You may also contact Customer Service for information on where to send a written complaint.

Consent to Telephone Calls and Text or Email Notifications

By enrolling in this employer sponsored group health plan, and providing your phone number and email address to your

employer or to Wellmark, you give express consent to Wellmark to contact you using the email address or residential or cellular telephone number provided via live or pre-recorded voice call, or text message notification or email notification. Wellmark may contact you for purposes of providing important information about your plan and benefits, or to offer additional products and services related to your Wellmark plan. You may revoke this consent by following instructions given to you in the email, text or call notifications, or by telling the Wellmark representative that you no longer want to receive calls.

Glossary

The definitions in this section are terms that are used in various sections of this coverage manual. A term that appears in only one section is defined in that section.

Accidental Injury. An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

Admission. Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

Amount Charged. The amount that a provider bills for a service or supply or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

BlueCard Program. The Blue Cross Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of Wellmark Blue POS Providers throughout the United States.

Compounded Drugs. Compounded prescription drugs are produced by combining, mixing, or altering ingredients by a pharmacist to create an alternate strength or dosage form tailored to the specialized medical needs of an individual patient when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs.

Continuing Care Patient is an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious or complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;

- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Creditable Coverage. Any of the following categories of coverage:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health

coverage provided under a plan established or maintained by a foreign country or political subdivision).

- A health benefits plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

Domestic Partner. An unmarried person who has signed the Certification of Domestic Partnership form with the plan member.

Domestic Provider. A facility or practitioner that participates directly with your employer's domestic provider network and also participates with the Wellmark Blue POS network. This is a provider that participates with ISU Thielen Student Health Center.

Extended Home Skilled Nursing. Home skilled nursing care, other than short-term home skilled nursing, provided in the home by a registered (R.N.) or licensed practical nurse (L.P.N.) who is associated with an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency that is ordered by a physician and consists of four or more hours per day of continuous nursing care that requires the technical proficiency and knowledge of an R.N. or L.P.N.

Group. Those plan members who share a common relationship, such as employment or membership.

Group Sponsor. The entity that sponsors this group health plan.

Habilitative Services. Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Illness or Injury. Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

Inpatient. Services received, or a person receiving services, while admitted to a health care facility for at least an overnight stay.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

Medically Urgent. A situation where a longer, non-urgent response time could seriously jeopardize the life or health of the plan member seeking services or, in the opinion 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.

Medicare. The federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member. A person covered under this group health plan.

Nonparticipating Pharmacy. A pharmacy that does not participate with the network used by your prescription drug benefits.

Office. An office setting is the room or rooms in which the practitioner or staff provide patient care.

Out-of-Network Provider. A facility or practitioner that does not participate with either the Wellmark Blue POS network or a Blue Cross or Blue Shield Plan in any other

state. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, Licensed Psychiatric or Mental Health Treatment Facility, Licensed Substance Abuse Treatment Facility, or the home.

Participating Pharmacy. A pharmacy that participates with the network used by your prescription drug benefits. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan, but not with the Wellmark Blue POS network.

Plan Member. The person who signed for this group health plan.

Plan Year. A date used for purposes of determining compliance with federal legislation.

Serious and Complex Condition. A condition, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that:
 - is life-threatening, degenerative, potentially disabling, or congenital; and
 - requires specialized medical care over a prolonged period of time.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this coverage

manual, that may be used to diagnose or treat a medical condition.

Specialty Drugs. Drugs that are typically used for treating or managing chronic illnesses. These drugs are subject to restricted distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or patient education that may not be provided by a retail pharmacy. Some specialty drugs may be taken orally, but others may require administration by injection or inhalation.

Spouse. A man or woman lawfully married to a covered member.

Urgent Care Centers provide medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

We, Our, Us. Wellmark Health Plan of Iowa, Inc.

Wellmark Blue POS Provider. A facility or practitioner that participates with Wellmark Health Plan of Iowa, Inc.

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

You, Your. The plan member and family members eligible for coverage under this group health plan.

Index

A

abuse of drugs 39
accidental injury 22
acupressure 19
acupuncture 15, 19
addiction 15, 20
administrative services 16, 30, 43
admissions 57, 58
adoption 71, 73
advanced registered nurse practitioners 16, 32
allergy services 15, 19
ambulance services 15, 19
ambulatory facility 26
ambulatory facility services 22
amount charged 66, 69
anesthesia 15, 20, 22
annulment 73, 74
antigen therapy 33, 39
appeals 57, 87
applied behavior analysis 20
arbitration 91, 92, 93
arbitration fees 93
artificial insemination 24
assignment of benefits 97, 98
audiologists 16, 32
authority to terminate or amend 95
authorized representative 95
autism 15, 20

B

benefit coordination 81
benefit levels 5, 47
benefit year 63, 67
benefit year deductible 7
benefits maximums 9, 15
bereavement counseling 22
biological products 32
blood 15, 20
Blue Distinction Center 36, 48
BlueCard program 49, 63

bone marrow transplants 36
braces 25, 28, 34
brain injuries 61
brand name drugs 68
breast reconstruction 35

C

capitation 67
care coordination 57
care management 61
changes of coverage 73, 74
chemical dependency 15, 20
chemical dependency treatment facility 26
chemotherapy 15, 21
child support order 72
children 71, 72, 73, 82
chiropractic services 16, 30
chiropractors 16, 32
claim filing 77, 81
claim forms 77
claim payment 78
claims 77
claims excluded by applicable law 93
class actions waiver 91
clinical trials 15, 21
COBRA coverage 73
coinsurance 6, 8, 11, 63
communication disorders 30
community mental health center 26
complaints 101
complications 43
compounded drugs 39
concurrent review 60
conditions of coverage 41
confidentiality 93
contact lenses 37
continuing care patient 54, 103
continuity of care 54, 103
contraceptive devices 39
contraceptives 15, 21
contract 95

contract amendment.....	95
contract interpretation.....	95, 97
convenience items	16, 28
convenience packaging.....	39
conversion therapy	15, 21
coordination of benefits.....	81
coordination of care	57
copayment	6, 7, 11
cosmetic drugs.....	39
cosmetic services	15, 22
cosmetic surgery.....	17, 35
counseling.....	16, 22
coverage changes	73, 74, 95
coverage continuation	75
coverage effective date	71
coverage eligibility	71, 73
coverage termination	74, 75
covered claims.....	91
creditable coverage	73
custodial care	25
cystic fibrosis.....	61

D

damaged drugs.....	39
death	73
deductible	7
deductible amounts	5
degenerative muscle disorders	61
dental services.....	16, 22
dependents.....	71, 72, 73, 82
DESI drugs.....	32
diabetes	16, 23
diabetic education.....	16, 23
diabetic supplies.....	28
dialysis.....	16, 23
dietary products	16, 22, 30, 39
disabled dependents	71
divorce.....	73, 74
doctors.....	16, 17, 32
doctors of osteopathy	16, 32
domestic partners	71
domestic providers	47
drug abuse	15, 20, 39
drug prior authorization.....	61
drug quantities	40, 68

drug rebates.....	67, 69
drug refills.....	40
drug tiers	68
drugs	17, 32, 37, 67
drugs that are not FDA-approved.....	33, 39

E

education	16, 22
effective date.....	71
eligibility for coverage	71, 73
emergency room copayment.....	5, 7
emergency services	16, 23, 53
employment physicals.....	34
EOB (explanation of benefits).....	78
exclusions	41, 42
expedited external review.....	89
experimental services.....	42
explanation of benefits (EOB).....	78
eye services	18, 37
eyeglasses	37

F

facilities	16, 26
family counseling.....	22
family deductible	7
family member as provider.....	43
FDA-approved A-rated generic drug.....	68
fertility services	16, 24
filing claims.....	77, 81
foot care (routine).....	27
foot doctors	17, 32
foreign countries.....	39, 51
foster children	71, 73
fraud.....	75

G

generic drugs.....	68
genetic testing	16, 24
government programs.....	43, 81
guest membership	53
gynecological examinations	17, 33

H

hairpieces.....	18, 37
hearing services.....	16, 24
hemophilia.....	61

high risk pregnancy..... 61
 home health services..... 16, 24
 home infusion therapy 33
 home office (Wellmark)..... 101
 home/durable medical equipment 16, 25
 hospice respite care..... 26
 hospice services 16, 26
 hospital services 22, 75
 hospitals 16, 26

I

ID card..... 48, 49, 55
 illness 16, 27
 impacted teeth..... 22
 infertility drugs..... 39
 infertility treatment 16, 24
 information disclosure 96
 infused drugs..... 39
 inhalation therapy 16, 25, 27
 injury..... 16, 27
 inpatient facility admission..... 57, 58
 inpatient services..... 63, 75
 inspection of coverage..... 101
 insulin 33
 investigational or experimental drugs..... 39
 investigational services..... 42
 irrigation solutions and supplies..... 39

K

kidney dialysis..... 23

L

L.P.N. 25
 laboratory services..... 18, 37
 licensed independent social workers 17, 32
 licensed practical nurses..... 25
 lifetime benefits maximum..... 44
 limitations of coverage 9, 15, 41, 44, 68
 lodging..... 17, 36
 long term acute care facility..... 27
 long term acute care services 27
 lost or stolen items..... 39

M

mammogram (3D)..... 33
 mammograms 17, 33

marriage 73
 marriage and family therapists 17, 32
 marriage counseling..... 22
 massage therapy 30
 mastectomy..... 35
 maternity services..... 16, 27
 maximum allowable fee..... 66, 69
 medicaid enrollment..... 98
 medicaid reimbursement..... 98
 medical doctors 16, 17, 32
 medical equipment 16, 25, 39
 medical evacuation 16, 29
 medical supplies 16, 28
 medical support order..... 72
 medically necessary 41
 Medicare..... 73, 81
 medication therapy management..... 33, 39
 medicines..... 17, 32, 37, 67
 mental health counselors..... 17, 32
 mental health services..... 16, 29
 mental health treatment facility 26
 mental illness..... 16, 29
 military service..... 43
 misrepresentation of material facts 75
 motor vehicles 16, 30
 muscle disorders..... 61
 musculoskeletal treatment..... 16, 30

N

network providers..... 5, 64
 network savings..... 66
 newborn children..... 73
 nicotine dependence 33, 34
 nicotine dependency drugs..... 38
 nonassignment of benefits..... 97
 nonmedical services..... 16, 30, 43
 nonparticipating pharmacies 55, 69
 notice..... 101
 notification of change..... 74
 notification requirements..... 57
 nursing facilities 26, 75
 nutrition education 16, 23
 nutritional products..... 16, 22, 30

O

occupational therapists 17, 32
 occupational therapy..... 16, 25, 31
 optometrists..... 17, 32
 oral contraceptives..... 21
 oral surgeons..... 17, 32
 organ transplants..... 17, 36
 orthotics (foot) 16, 31
 osteopathic doctors..... 16, 32
 other copayment..... 6, 8
 other insurance..... 43, 81
 out-of-area coverage 39, 49, 63
 out-of-network providers 5, 64
 out-of-pocket maximum..... 6, 8, 11
 outpatient copayment 6, 8
 oxygen..... 25, 28

P

packaging..... 39
 Pap smears..... 17, 33
 participating pharmacies..... 54, 69
 participating providers..... 47, 64
 payment arrangements 66, 69
 payment in error..... 100
 payment obligations 5, 8, 9, 12, 41, 45, 55, 58, 63, 68, 69
 personal items..... 16, 28
 physical examinations..... 17, 33
 physical therapists..... 17, 32
 physical therapy 16, 25, 31
 physician assistants 17, 32
 physicians 16, 17, 32
 plan year..... 95
 plastic surgery 15, 22
 podiatrists..... 17, 32
 practitioners..... 16, 32
 precertification..... 44, 57
 pregnancy 27
 pregnancy (high risk)..... 61
 prenatal services..... 27
 prescription drugs 17, 32, 37, 67, 68
 preventive care 17, 33
 preventive items 38
 preventive services..... 38
 prior approval 44, 59

prior authorization..... 44, 61
 privacy..... 96
 prosthetic devices 17, 25, 34
 provider network 5, 47, 64
 psychiatric medical institution for children (PMIC)..... 26
 psychiatric services 29
 psychologists..... 17, 32
 pulmonary therapy 16, 25, 27

Q

qualified medical child support order 72
 quantity limits 40, 68

R

R.N. 16, 25, 28, 32
 radiation therapy 15, 21
 rebates..... 67, 69
 reconstructive surgery..... 17, 35
 referrals 48
 refills 40
 registered nurses 16, 25, 28, 32
 reimbursement of benefits..... 98, 100
 release of information 96
 removal from coverage..... 73
 repatriation..... 17, 35
 respiratory therapy 16, 25, 27
 rights of appeal..... 87
 routine services 17, 33

S

self-help..... 17, 35
 separation..... 73, 74
 serious and complex condition..... 54, 105
 service area 49
 short-term home skilled nursing..... 25
 skilled nursing services 16, 25, 27
 sleep apnea 17, 35
 social adjustment..... 17, 35
 social workers..... 17, 32
 specialty drugs..... 33
 specialty pharmacy program..... 55
 speech pathologists..... 17, 32
 speech therapy 17, 35
 spinal cord injuries 61
 sports physicals..... 34

spouses 71, 73
 stepchildren 71
 sterilization 24
 students 71, 73
 subrogation 98
 surgery 17, 35
 surgical facility 26
 surgical facility services 22
 surgical supplies 16, 28
 survival and severability of terms 93

T

take-home drugs 33, 37
 telehealth 17, 36
 temporomandibular joint disorder 17, 36
 termination of coverage 74, 75
 therapeutic devices 39
 third party liability 43
 TMD (temporomandibular joint disorder) . 17, 36
 tooth removal 22
 transplants 17, 36, 61

travel 17, 36
 travel physicals 34
 tubal ligation 24

U

urgent care center 27

V

vaccines 32
 vasectomy 24
 vehicles 16, 30
 vision services 18, 37

W

weight reduction drugs 39
 well-child care 17, 34
 Wellmark drug list 67
 wigs 18, 37
 workers' compensation 43, 100

X

x-rays 18, 37



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

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

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

တၢ်ဒုးသုဂ်ညါ-န့ၢ်ကတိၢ်ကေညါကိၣ်, ကိၣ်တၢ်မၤစၢတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘၣ်လၢတဘၣ်လၢ, ဆိၣ်လၢန့ၢ်လိၤဆဲးကိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ န့ၣ်တဖၣ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တက့ၢ်.

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

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ທີ່ຕໍ່ຕິ. (TTY: 888-781-4262.)

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ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'éhjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hółne' 800-524-9242 doodaii' (TTY: 888-781-4262)

