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B E N E F I T B O O K L E T

State of Iowa
DEDUCTIBLE 3 PLUS – 20%

Classic Blue Plan

If you have questions about your coverage or about a specific claim, call the Wellmark Blue Cross and Blue Shield of Iowa customer service unit for State employees.

Des Moines Area: **515-245-5185** ● Toll Free: **800-622-0043**

For Precertification: **800-558-4409**

Group Effective Date: 1/1/2015
Plan Year: 01/01
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Coverage Code: EE5 EE7 EE3
Version: 01/15

Form Number: Wellmark IA Grp (SOI Deductible 3 Plus - V)

NOTICE

This group health plan is sponsored and funded by your employer or group sponsor. Your employer or group sponsor has a financial arrangement with Wellmark under which your employer or 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.

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About This Benefit Booklet

Contract

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

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

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

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 booklet. (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 booklet. 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 benefit booklet, 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.

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 benefit booklet, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

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.

Category	You Pay
Deductible	
	$300 for a single contract **$400** (maximum) for a family contract*
Coinsurance	
	20%
Out-of-Pocket Maximum	
	$600 for a single contract **$800** (maximum) for a family contract*

*Family amounts are reached from amounts accumulated on behalf of any covered family member or combination of covered family members. You must satisfy the entire family deductible before we make benefit payments.

Payment Details

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 covered family member or combination of covered family members.

You must satisfy the entire family deductible before we make benefit payments.

Once you meet the deductible, then coinsurance applies.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year.

If a family member is removed from your coverage during the benefit year and this changes your coverage type from family to single coverage, you will not be credited with deductible amounts that were paid during the benefit year on behalf of the removed family member. As of the date of the coverage change, you will be responsible for any applicable deductible that remains unmet in the absence of amounts that were paid on behalf of the removed family member. See *Coverage Changes and Termination*, page 47.

Common Accident Deductible. When two or more covered family members are involved in the same accident and they receive covered services for injuries related to the accident, only one deductible amount will be applied to the accident-related services for all family members involved. However, you still need to satisfy the family (not the per person) out-of-pocket maximum.

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

Prior Deductible Credit. When you are covered by another State of Iowa health care plan administered by Wellmark Blue Cross and Blue Shield of Iowa immediately before becoming covered under this plan, any deductible amounts from the previous plan may be applied to help you meet the deductible under this plan. This is true when your coverage under both plans is for the same benefit year.

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 39. 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. These amounts include:

- Deductible.
- Coinsurance.
- Amounts you pay for covered prescription drugs.

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

Out-of-pocket deductible maximum amounts that accumulate during the last three months of a benefit year carry over as credits to meet your out-of-pocket maximum for the next benefit year.

If a family member is removed from your coverage during the benefit year and this changes your coverage type from family to single coverage, you will not be credited with out-of-pocket maximum amounts that were paid during the benefit year on behalf of the removed family member. As of the date of the coverage change, you will be responsible for any applicable out-of-pocket maximum that remains unmet in the absence of amounts that were paid on behalf of the removed family member. See *Coverage Changes and Termination*, page 47.

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 25.

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

Benefits Maximums

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

Benefits maximums are accumulated from benefits under this medical benefits plan and prior medical benefits plans sponsored by the State of Iowa and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Accident care received in an office or the outpatient department of a facility. Care must be received within 72 hours of the injury.	Coinsurance
Ambulance services for treatment of mental health conditions and chemical dependency.	Coinsurance
Breast pumps (manual) purchased from a covered participating or BlueCard home/durable medical equipment provider.	Deductible Coinsurance
Contraceptive medical devices, such as intrauterine devices and diaphragms received from participating or BlueCard providers.	Deductible Coinsurance
Contraceptive drugs and contraceptive drug delivery devices (e.g., birth control patches).	Deductible Coinsurance
Emergency room services.	Coinsurance
Home health services for treatment of mental health conditions and chemical dependency.	Coinsurance
Implanted and injected contraceptives received from participating or BlueCard providers.	Deductible Coinsurance
Mental health conditions and chemical dependency treatment – outpatient services.	Coinsurance
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services for the first six days.	Deductible Coinsurance
Postpartum home visit (one) when a mother and her baby are voluntarily discharged from the hospital within 48 hours of normal labor and delivery or within 96 hours of cesarean birth.**	Deductible Coinsurance
Prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician.	Deductible Coinsurance

Covered Service	Payment Obligation Waived
Preventive care, items, and services,* received from participating or BlueCard providers, as follows: ■ 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; ■ 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.	Deductible Coinsurance
Prosthetic limb devices received from participating providers.	Deductible
Surgery and related services, including x-ray and lab – office and outpatient services.	Coinsurance
Voluntary sterilization for female members received from participating or BlueCard providers.	Deductible Coinsurance
Well-child care.	Deductible

*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.

**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 the 48-96 hour mandated requirement. If that occurs, a separate deductible and coinsurance will be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child.

2. At a Glance - Covered and Not Covered

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 benefit booklet. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 11. To fully understand which services are covered and which are not, you must become familiar with this entire benefit booklet. 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 the State of Iowa and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Category	Covered	Not Covered	See Page	Benefits Maximum
Acupuncture Treatment		⦸	11	
Allergy Testing and Treatment	●		11	
Ambulance Services	●		11	
Anesthesia	●		11	
Blood and Blood Administration	●		11	
Chemical Dependency Treatment	●		11	
Chemotherapy and Radiation Therapy	●		12	
Clinical Trials	●		12	
Contraceptives	●		12	
Cosmetic Services		⦸	12	
Counseling and Education Services		⦸	13	
Dental Treatment for Accidental Injury	●		13	
Dialysis	●		13	

Category	Covered	Not Covered	See Page	Benefits Maximum
Education Services for Diabetes	●		13	
Emergency Services	●		14	
Fertility and Infertility Services	●		14	$25,000 per lifetime for infertility transfer procedures and the collection or purchase of donor semen or oocytes.
Genetic Testing	●		14	
Hearing Services (related to an illness or injury)	●		14	
Home Health Services	●		15	The daily benefit for home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		15	
Hospice Services	●		16	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	●		16	
Illness or Injury Services	●		17	
Inhalation Therapy	●		17	
Maternity Services	●		17	
Medical and Surgical Supplies	●		18	
Mental Health Services	●		18	
Morbid Obesity Treatment	●		19	
Motor Vehicles		⦸	19	
Musculoskeletal Treatment	●		19	
Nonmedical Services		⦸	20	
Occupational Therapy	●		20	
Orthotics		⦸	20	
Over-the-Counter Products		⦸	20	
Physical Therapy	●		20	
Physicians and Practitioners			21	
Advanced Registered Nurse Practitioners	●		21	
Audiologists	●		21	
Chiropractors	●		21	
Doctors of Osteopathy	●		21	
Licensed Independent Social Workers	●		21	
Medical Doctors	●		21	
Occupational Therapists	●		21	
Optometrists	●		21	

Category	Covered	Not Covered	See Page	Benefits Maximum
Oral Surgeons	●		21	
Physical Therapists	●		21	
Physician Assistants	●		21	
Podiatrists	●		21	
Psychologists	●		21	
Speech Pathologists	●		21	
Prescription Drugs	●		21	
Preventive Care	●		22	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.
Prosthetic Devices	●		23	
Reconstructive Surgery	●		23	
Self-Help Programs		⦸	23	
Sleep Apnea Treatment	●		23	
Speech Therapy	●		23	
Surgery	●		23	
Temporomandibular Joint Disorder (TMD)	●		24	
Transplants	●		24	
Travel or Lodging Costs		⦸	24	
Vision Services (related to an illness or injury)	●		24	
Wigs or Hairpieces		⦸	24	
X-ray and Laboratory Services	●		24	

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 benefit booklet. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25. If a service or supply is not specifically listed, do not assume it is covered.

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

All of the following are required to qualify for benefits:

- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.
- No other method of transportation is appropriate.
- In addition to the preceding requirements, for air ambulance services to be covered, all of the following conditions must be met:
  - The air ambulance has the necessary patient care equipment and supplies to meet your needs.
  - Your medical condition requires immediate and rapid ambulance transport that cannot be provided by a ground ambulance; or the point of pick up is inaccessible by a land vehicle.
  - Great distances, limited time frames, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment.
  - Your condition is such that the time needed to transport you by land poses a threat to your health.

Not Covered: Professional air ambulance transport from a facility capable of treating your condition when performed primarily for your convenience or the convenience of your family, physician, or other health care provider.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Blood and Blood Administration

Covered: Blood and blood administration.

Chemical Dependency Treatment

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

For treatment in a residential treatment facility, benefits are available:

- For treatment provided on an intensive outpatient basis, but not including charges related to residential care;

- For partial hospitalization treatment, but not including charges related to residential care;
- For sub-acute, medically monitored inpatient treatment for patients whose condition requires 24-hour licensed registered nurse observation, monitoring, and treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program; 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.

Coverage for Psychiatric Medical Institutions for Children (PMIC) is separately addressed in this benefit booklet and is not subject to the preceding provision.

Not Covered:

- Treatment received in a residential treatment facility, except as described under *Covered*.

See Also:

Hospitals and Facilities later in this section.

Chemotherapy and Radiation Therapy

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

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 participating 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;
- 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.
- Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.
- Implanted contraceptives.
- Injected contraceptives.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. 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

Not Covered:

- Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.
- Education or educational therapy other than covered education for self-management of diabetes.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes later in this section.

Mental Health Services later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:
  - Treatment is completed within six months of the injury.
- 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) as an outpatient. Inpatient removal is covered 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 required for surgical management of cleft palate.
- Treatment of abnormal changes in the mouth due to disease.

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 surgical 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

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.

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 participating provider, covered services will be reimbursed as though they were received from a participating provider. However, because we do not have contracts with nonparticipating providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

See Also:

Nonparticipating providers, page 40.

Fertility and Infertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
- Infertility testing and treatment for infertile members including in vitro fertilization, gamete intrafallopian transfer (GIFT), and pronuclear stage transfer (PROST).
- The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures; freezing of sperm, oocytes, or embryos.

Benefits Maximum:

- **$25,000** per lifetime for infertility transfer procedures and the collection or purchase of donor semen or oocytes.

Not Covered:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

See Also:

Prescription Drugs later in this section.

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:

- Hearing examinations, but only to test or treat hearing loss related to an illness or injury.

Not Covered:

- Hearing aids.
- Routine hearing examinations.

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 our case manager 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 prescribed by a physician and approved by a Wellmark case manager.

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.

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. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. The daily benefit for home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Home skilled nursing will be coordinated by a case manager. Custodial care is not included in this benefit.

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.

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 sanitaria care or rest cures.

See Also:

Case Management, page 36.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.

- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

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. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies later in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 27.

Prosthetic Devices later in this section.

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.

Chemical Dependency Treatment Facility. This type of facility provides treatment of chemical dependency and must be licensed and approved by Wellmark.

Community Mental Health Center. This type of facility provides outpatient treatment of mental health conditions and must be licensed and approved by Wellmark.

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. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

Residential Treatment Facility. This is a licensed facility other than a hospital or nursing facility that provides:

— treatment on an intensive outpatient basis;
— partial hospitalization treatment;
— sub-acute, medically monitored inpatient treatment for patients whose condition requires 24-hour licensed registered nurse observation, monitoring, and

treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program;

— 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.

Coverage for Psychiatric Medical Institutions for Children (PMIC) is separately addressed in this benefit booklet and is not subject to the preceding provision.

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.

Prior approval is required and benefits will be provided pursuant to the Iowa mandate. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this benefit booklet, or call the Customer Service number on your ID card.

Not Covered:

- Treatment received in a residential treatment facility, except as described under *Covered*.

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.

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.

Inhalation Therapy

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

Maternity Services

Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Please note: You must notify us or your employer or group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your employer or 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.

If the inpatient hospital stay is shorter, coverage includes a 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 the 48-96 hour mandated requirement. If that occurs, a separate deductible and coinsurance will be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child.

See Also:

Coverage Change Events, page 47.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies including insulin syringes.

Not Covered:

- 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.

Orthotics later in this section.

Prescription Drugs later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 27.

Prosthetic Devices later in this section.

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.

Coverage includes diagnosis and treatment of these biologically based mental illnesses:

- Schizophrenia.
- Bipolar disorders.
- Major depressive disorders.
- Schizo-affective disorders.
- Obsessive-compulsive disorders.
- Pervasive developmental disorders.
- Autistic disorders.

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, Fourth Edition-Revised* (DSM-IV-R) or subsequent revisions.
- 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.
- The disorder is not a chemical dependency condition.
- The disorder is a behavioral or psychological condition not attributable to a mental disorder that is the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered covered under your medical benefits.

For treatment in a residential treatment facility, benefits are available:

- For treatment provided on an intensive outpatient basis, but not including charges related to residential care;
- For partial hospitalization treatment, but not including charges related to residential care;
- For sub-acute, medically monitored inpatient treatment for patients whose condition requires 24-hour licensed registered nurse observation, monitoring, and treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program; 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.

Coverage for Psychiatric Medical Institutions for Children (PMIC) is separately addressed in this benefit booklet and is not subject to the preceding provision.

Please note: Your employer's Employee Assistance Program (EAP) may be able to provide counseling services for certain conditions. For more information, contact your EAP coordinator.

Not Covered:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual disorders and gender identity disorders.
- Treatment received in a residential treatment facility, except as described under *Covered*.

See Also:

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

Morbid Obesity Treatment

Covered: Weight reduction surgery provided the surgery is medically necessary for your condition. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is required. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this benefit booklet, or call the Customer Service number on your ID card.

Not Covered:

- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

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: Massage therapy.

Nonmedical 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 any services or supplies that are nonmedical.

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 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

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.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 27.

Prosthetic Devices later in this section.

Over-the-Counter Products

Not Covered: Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products (e.g., products prescribed by a physician and over-the-counter tobacco dependency drugs) may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.

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 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.

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 29.

Prescription Drugs

Covered:

- Prescription drugs and medicines received as an inpatient or outpatient of a facility.
- Prescriptions purchased from a licensed retail pharmacy.
- Any state sales tax associated with the purchase of a covered prescription drug.

A prescription drug is one that bears the legend, "Caution, Federal Law prohibits dispensing without a prescription."

Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered.

Prescription drugs purchased outside the United States are covered only if all of the following requirements are met:

- You are injured or become ill while in a foreign country.
- The drug is FDA-approved or an FDA equivalent and has the same name as the FDA-approved drug.
- The drug would require a written prescription by a licensed M.D. or D.O. if prescribed in the United States.
- You provide acceptable documentation that you received a covered service from a physician or hospital and the physician or hospital prescribed the drug.

Additional prescription drugs and medicines covered under this medical benefits plan 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.

Infertility Prescription Drugs.

Insulin.

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

when provided in the home (home infusion therapy).

Nicotine Dependence. Prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician are covered under your medical benefits. Related medical evaluations are also covered.

Not Covered:

- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Mail order prescriptions.
- Prescription drugs that are not FDA-approved.

See Also:

Contraceptives earlier in this section.

Medical and Surgical Supplies earlier in this section.

Notification Requirements and Care Coordination, page 33.

Prior Authorization, page 37.

Preventive Care

Covered: Preventive care such as:

- Gynecological examinations.
- Mammograms.
- Medical evaluations related to nicotine dependence.
- 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;
  - 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.

Not Covered:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

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 eyeglasses and 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 earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 27.

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.

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.

Speech Therapy

Covered: Rehabilitative speech therapy services when related to a specific illness, injury, or impairment and 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: Gender reassignment surgery.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: 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.

Transplants are subject to Case 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.

Not Covered:

- 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:

Case Management, page 36.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Vision examinations but only when related to an illness or injury.

Not Covered:

- Surgery to correct a refractive error (i.e., when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Prescribing of corrective lenses.
- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

Wigs or Hairpieces

Not Covered.

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.

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. 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 is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
  - Any other relevant factors.
- 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 a nonparticipating provider; or
- You receive the services from a participating provider in the Wellmark service area 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

participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area 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 43.

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, 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.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association, including whether a service, supply, device, 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 and 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, 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 a nonparticipating provider; or
- You receive the services from a participating provider in the Wellmark service area 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 participating provider is responsible for these amounts.
- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area 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 12.

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 Services
You are not covered for telephone consultations, charges for missed appointments, charges for completion of any form, or charges for information.

Personal Convenience Items
You are not covered for items used for your personal convenience, such as:

- 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, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

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:

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay 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 that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

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

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 benefit maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered,* page 11.

- 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 4, and *At a Glance–Covered and Not Covered*, page 7.
- If you do not obtain precertification for certain medical services, benefits can be reduced or denied. You are responsible for benefit reductions if you receive the services from a nonparticipating provider. You are responsible for benefit denials only if you are responsible (not your provider) for notification. See *Notification Requirements and Care Coordination*, page 33.
- 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. See *Notification Requirements and Care Coordination*, page 33.
- If you do not obtain prior authorization for certain prescription drugs, benefits can be reduced or denied. See *Notification Requirements and Care Coordination*, page 33.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 29, and *Factors Affecting What You Pay*, page 39. Examples of charges that depend on the type of provider include but are not limited to:
  - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from a nonparticipating practitioner.

5. Choosing a Provider

Your medical benefits are called Classic Blue.

Although Classic Blue allows you to receive covered services from almost any provider who is eligible to provide the services, it is usually to your advantage to receive services from participating providers. Participating providers participate with a Blue Cross and/or Blue Shield Plan. You will usually pay less for services you receive from participating providers than for services you receive from nonparticipating providers.

Providers who do not participate with a Blue Cross and/or Blue Shield Plan are called nonparticipating providers.

See *What You Pay,* page 3 and *Factors Affecting What You Pay,* page 39.

To determine if a provider participates with your medical benefits, ask your provider, or call the Customer Service number on your ID card.

Providers are independent contractors and are not agents or employees of Wellmark Blue Cross and Blue Shield of Iowa. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 16 and *Physicians and Practitioners*, page 21.

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 participating, particular providers within the facility may not be participating providers. Examples include nonparticipating physicians on the staff of a participating hospital, home medical equipment suppliers, and other independent providers. Therefore, when you are referred by a participating provider to another provider, or when you are admitted into a facility, always ask if the providers contract with a Blue Cross and/or Blue Shield Plan.

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 do not participate with Classic Blue. Pharmacies typically do not provide services and supplies considered medical benefits under the plan, and are not considered participating providers for such benefits.

Provider Comparison Chart	**Participating**	**Nonparticipating**
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	No
Minimizes your payment obligations. See *What You Pay,* page 3.	Yes	No
Claims are filed for you.	Yes	No
Blue Cross and/or Blue Shield pays these providers directly.	Yes	No
Notification requirements are handled for you.	No	No

Services Outside the Wellmark Service Area

Whenever possible, before receiving services outside the Wellmark service area, you should 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*.

Iowa and South Dakota comprise the Wellmark service area.

Laboratory services. You may have laboratory specimens or samples collected by a participating 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, that provider will be considered a nonparticipating provider and you will be responsible for any applicable nonparticipating provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

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, that provider will be considered a nonparticipating provider and you will be responsible for any applicable nonparticipating provider payment obligations 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, that provider will be considered nonparticipating and you will be responsible for any applicable nonparticipating provider payment obligations 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 Wellmark's service area, 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, that provider will be considered a nonparticipating provider and you will be responsible for any applicable nonparticipating provider payment obligations 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, that provider will be considered nonparticipating and you will be responsible for any applicable nonparticipating provider payment obligations 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 Wellmark's service area, 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 *Nonparticipating Providers,* page 40.

BlueCard Program. We have relationships with other Blue Cross and/or Blue Shield Plans. These relationships are generally referred to as Inter-Plan Programs. Whenever you obtain services outside Iowa or South Dakota, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program. These programs ensure that members of any Blue Plan have access to the advantages of participating providers throughout the United States. Participating providers have a contractual agreement with the Blue Cross 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 Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a participating 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.

When you receive covered services from BlueCard providers outside the Wellmark service area, 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 health plan payment is sent directly to the providers.

Typically, when you receive covered services from BlueCard providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 33. However, if you are admitted to a BlueCard facility outside the Wellmark service area, any BlueCard provider will handle notification requirements for you.

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 nonparticipating except for services received from providers that participate with BlueCard Worldwide.

6. Notification Requirements and Care Coordination

Many 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.

BlueCard Providers and Notification Requirements
Typically, only BlueCard providers in Iowa and South Dakota handle notification requirements for you. However, if you are admitted to a BlueCard facility outside Iowa or South Dakota, any BlueCard provider will handle notification requirements for you.

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a BlueCard provider outside Iowa or South Dakota, you or someone acting on your behalf are 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 or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 59. Also see *Authorized Representative*, page 63.

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 *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	Participating providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for precertification if: ▪ You receive services subject to precertification (other than services you receive as an inpatient in a facility) from a provider outside Iowa or South Dakota; ▪ You receive services subject to precertification from a nonparticipating provider.

Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. 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.
Importance	If you choose to receive services subject to precertification and we determine that the procedure was not medically necessary, you will be responsible for the charges. If you receive the services from a nonparticipating provider and we determine the procedure is medically necessary and otherwise covered, without precertification, benefits can be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed $500 per benefit year. See *Maximum Allowable Fee*, page 41. You are subject to this benefit reduction only if you receive the services from a nonparticipating provider. Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *What You Pay*, page 3.

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 *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	Participating providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf are responsible for notification if: ■ You receive services subject to notification (other than services you receive as an inpatient in a facility) from a provider outside Iowa or South Dakota; ■ You receive services subject to notification from a nonparticipating provider.
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.

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.
Applies to	For a complete list of the services subject to prior approval, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	Participating providers in the states of Iowa and South Dakota request prior approval for you. You are responsible for prior approval if: ■ You are admitted to a facility outside Iowa or South Dakota; ■ You receive services subject to prior approval from a provider outside Iowa or South Dakota; ■ You receive services subject to prior approval from a nonparticipating provider.
Process	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. 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: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.
Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefit maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. 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. 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, the benefit for that service will be provided according to the terms of your medical benefits. 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.

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 *Precertification* and *Notification* earlier in this section.

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 *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary. Responses to Wellmark's concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.
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.

Case Management

Purpose	Case management is a process of considering alternative treatments for members with severe illnesses or injuries that require costly, long-term care. Depending on the individual circumstances, a hospital may not be the most appropriate setting for treatment.
Applies to	Examples where case management might be appropriate include but are not limited to: Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Home Health Services Pregnancy (high risk) Transplants
Person Responsible	You, your physician, and the health care facility can work with Wellmark's case managers to identify and arrange alternative treatment plans to meet special needs. Wellmark may initiate a request for case management.

Process	Wellmark's case managers try to identify alternative settings or treatment plans, provided costs do not exceed those of an inpatient facility. A benefit program is tailored to the circumstances of the case. Even if a service is not covered or is subject to a specific limitation, Wellmark may waive exclusions or limitations with the agreement of its medical director. If your current level or setting of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified at least 24 hours before benefits end.
Importance	Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.

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. In some cases prior authorization may also allow a drug that is normally excluded to be covered if it is part of a specific treatment plan and medically necessary.
Applies to	Prior authorization is required for a number of particular drugs. Visit *Wellmark.com* or 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.

Benefit Year

A benefit year is the same as a calendar year. It begins on the effective date of the agreement between Wellmark Blue Cross and Blue Shield of Iowa and your employer or group sponsor and starts over each January 1. Your benefit year continues even if your employer or group sponsor changes Wellmark group health plan benefits during the year.

If you change coverage and your Wellmark identification number is changed, a new benefit year will start under the new ID number for the rest of the calendar year. In this case, the benefit year would be less than a full year.

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 renew and will be based on the benefit limitations and payment obligation 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.
- Benefit 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.

Participating and Nonparticipating 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 25.

BlueCard Providers Outside the Wellmark Service Area

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 25.

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, going forward, also take into account 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 amount charged 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 25.

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 31.

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with participating providers. When you receive services from participating providers:

- The participating payment obligation amounts may be waived or may be less than the nonparticipating amounts for certain covered services. See *Waived Payment Obligations*, page 5.
- These providers agree to accept Wellmark's payment arrangements or payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Nonparticipating Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with nonparticipating providers, and they may not accept our payment arrangements. Pharmacies are considered nonparticipating providers. Therefore, when you receive services from nonparticipating providers:

- You are responsible for any difference between the amount charged and the maximum allowable fee for a covered service when the maximum allowable fee is less than the practitioner's charge. In the case of services received outside Iowa or South Dakota, our maximum payment for services by a nonparticipating provider may be the lesser of Wellmark's maximum allowable fee or the amount allowed by the Blue Cross or Blue Shield Plan in the state where the provider is located. See *Services Outside the Wellmark Service Area,* page 30.
- Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.
- The health plan payment for nonparticipating hospitals, M.D.s, and D.O.s in Iowa 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 billed balance you may owe).

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 participating 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 provider. For the majority of services, the savings reflects the actual amount you saved 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 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 are responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; reductions or denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 25.
- *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.
  - Amounts representing any general exclusions and conditions.
  - Network savings.

Payment Method for Services

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. 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.

Wellmark Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List contains drugs physicians recognize as medically

effective for a wide range of health conditions.

The Wellmark Drug List was developed with the assistance of physicians, pharmacists, and Wellmark's pharmacy benefits manager. It is not a required list of medications and physicians are not limited to prescribing only the drugs that appear on the list. Physicians may prescribe any medication, and that medication will be covered unless it is specifically excluded under your medical benefits, or other limitations apply.

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our website, *Wellmark.com*.

The Wellmark Drug List is subject to change.

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.

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 employer's or group sponsor's eligibility requirements. Also eligible for coverage is an eligible member's spouse or domestic partner.

A child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member or an enrolled spouse or domestic partner:

- A natural 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 natural child a court orders to be covered.

Please note: You must notify us or your employer or group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your employer or 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 over the age of 26 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 over the age of 26 who is totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 26, or while the child was a full-time student. In addition, the child must have had creditable coverage without a break of 63 days or more since turning age 26 or since becoming a full-time student.

When Plan Member and Spouse Are Both Eligible Employees

When a husband and wife are both employed by the State, they must enroll under the same family coverage. Employees cannot be covered as both an employee and a dependent under the State's health plans.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 47.

Enrollment Requirements

Permanent or probationary employees who work 20 or more hours per week are eligible to apply:

- within 30 calendar days of the date of hire; or
- at the annual change period.

Promise Program

Promise Program employees, as established by Executive Order Number 27, may enroll in single or family coverage within 30 calendar days of expiration of their Medicaid benefits.

Program Selection/Program Movement

Rules on program selection and program movement are detailed in your *Employer's Procedures Manual* and *Collective Bargaining Agreements*.

When Coverage Begins

Coverage begins on the member's effective date.

Your coverage under this group health plan begins on your effective date, which is the first of the month following 30 days of active employment. **Please note:** The month of February is considered a 30-day period.

Any employee or former employee defined as eligible by the State of Iowa, whether actively at work or not, is accepted by the group health plan during an approved enrollment and change period.

This benefit booklet supersedes any other contractual language regarding the member's effective date, benefits available, eligibility, or payment for inpatient hospital, nursing facility, practitioner, or other inpatient charges for State of Iowa group members.

Services received before the effective date of coverage are not eligible for benefits.

Late Enrollees

A late enrollee is a member who declines coverage when initially eligible to enroll and then later wishes to enroll for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity. See *Coverage Change Events*, page 47.

A late enrollee may enroll for coverage at the group's next renewal or enrollment period.

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 employer or 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 employer or group sponsor will promptly notify you or your spouse and the dependent that the order has been received. The employer or 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 employer or 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 employer or group sponsor will withhold any applicable share of the dependent's health care premiums from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after the insurer receives the QMCSO, your employer or 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 employer or group sponsor may not revoke enrollment or eliminate coverage for a dependent unless the employer or 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 employer eliminates dependent health coverage for all employees.

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

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

Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993 (FMLA), requires a covered employer to allow an employee with 12 months or more of service who has worked for 1,250 hours over the previous 12 months and who is employed at a worksite where 50 or more employees are employed by the employer within 75 miles of that worksite a total of 12 weeks of leave per fiscal year for the birth of a child, placement of a child with the employee for adoption or foster care, care for the spouse, child or parent of the employee if the individual has a serious health condition or because of a serious health condition, the employee is unable to perform any one of the essential functions of the employee's regular position. In addition, FMLA requires an employer to allow eligible employees to take up to 12 weeks of leave per 12-month period for qualifying exigencies arising out of a covered family member's active military duty in support of a contingency operation and to take up to 26 weeks of leave during a single 12-month period to care for a covered family member recovering from a serious illness or injury incurred in the line of duty during active service.

Any employee taking a leave under the FMLA shall be entitled to continue the employee's benefits during the duration of the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. **Please note:** The employee is still responsible for paying their share of the premium if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the FMLA does not constitute a qualifying event so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee

does not return at the end of the approved period of Family and Medical Leave and terminates employment with employer, the COBRA qualifying event occurs at that time.

If you have any questions regarding your eligibility or obligations under the FMLA, contact your employer or group sponsor.

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: Review the Department of Administrative Services' benefits website (*http://benefits.iowa.gov*) for a list of events that allow changes to your health insurance enrollment.

Requirement to Notify Group Sponsor

You must notify your employer or group sponsor of an event that changes the coverage status of members.

Birth of a Child. A newborn will be added to the existing family health contract when information becomes available from any valid source that the birth has occurred (e.g., hospital or professional claims submission or an enrollment form). The effective date of enrollment will be the date of birth.

If a single contract is in effect at the time of the birth of a biological child, the employee must submit an application form to change to a family contract within 60 days of the date of the birth. The effective date of the family contract will be the first day of the month in which the biological child was born. Appropriate employee deductions for payment of the family contract must be paid retroactively to reflect the change to a family contract.

If the single contract holder does not submit the application for family coverage within 60 days of the birth of the biological child, benefit payments will not be made retroactive to the date of birth.

Adoption, Legal Custody, or Legal Guardianship. The following provisions apply for adoptions or obtaining legal custody or legal guardianship:

If a newborn child is adopted within 30 days of birth or has been placed in your home for the purposes of adoption within 30 days of birth, the effective date of coverage can be:

- the first of the month, in which the child was born; or
- the first of the month following the child's birth.

If you adopt a child or a child is placed in your home for the purposes of adoption more than 30 days after the child's date of birth, the effective date of coverage will be the first of the month in which the adoption or placement for adoption occurs. If you obtain legal custody or legal guardianship of a child more than 30 days after the child's date of birth, the effective date of coverage will also be the first of the month in which the legal action occurs.

Your application for coverage must be signed within 60 days of the event to add the new child to the existing family contract or allow a single contract to be changed to a family contract.

Legal documentation must accompany the application to add the new child indicating:

- employee name and social security number;
- date of birth of the child; and
- date awarded physical custody.

If custody is lost, it is the employee's responsibility to immediately notify their human resources associate or personnel assistant.

Medicaid or the Children's Health Insurance Program. Notify your employer or group sponsor within 60 days in case of the following events:

- 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.

All Other Events. For all other events, you must notify your employer or group sponsor within 30 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.

If you do not provide timely notification of a coverage enrollment event, the affected person may not enroll until an annual group enrollment period.

Coverage Termination

The following events terminate your coverage eligibility.

- You become unemployed when your eligibility is based on employment.
- You become ineligible under your employer's or group sponsor's eligibility requirements for reasons other than unemployment.
- Your employer or group sponsor discontinues or replaces this group health plan.
- We terminate coverage of all similar group health plans by written notice to your employer or group sponsor 90 days prior to termination.

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 employer or 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 employer or 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

Your coverage will terminate immediately if you or your employer or group sponsor fails to make required payments to us when due.

Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this group health plan or to convert to another Wellmark health benefits plan pursuant to certain state and federal laws.

COBRA Continuation

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and eligible dependents to continue coverage if it is lost due to a qualifying event, such as employment termination, divorce, or loss of dependent status. You and your eligible dependents will be required to pay for continuation coverage. Other federal or state laws similar to COBRA may apply if COBRA does not. Your employer or group sponsor is required to provide you with additional information on continuation coverage if a qualifying event occurs.

Continuation for Public Group

Iowa Code Sections 509A.7 and 509A.13 may apply if you are an employee of the State. Iowa Code Section 509A.13A may apply to the surviving spouse of a retired State employee. These laws may entitle you to continue participation in this medical benefits plan when you retire.

10. Claims

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

When to File a Claim

You need to file a claim if you:

- Use a provider or pharmacy who does not file claims for you. Participating providers file claims for you.

Wellmark must receive claims within 365 days following the date of service of the claim. Effective January 1, 2015, Wellmark must receive claims within 180 days following the date of service of the claim.

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 Claim Form. For prescription drugs covered under your medical 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.

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. Send the claim to:

Wellmark Blue Cross and Blue Shield of Iowa
Station 1E238
P.O. Box 9291
Des Moines, IA 50306-9291

Prescription Drug Claims. Send the claim to:

Catamaran
Claims Department
P.O. Box 368022
Schaumburg, IL 60196-8022

Claims for Services Received Outside the United States. Send the claim to:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126

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

Notification of Decision

We will send 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 53.

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 for up to 18 months after we first process the claim. In the case of nonparticipating 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.

11. Coordination of Benefits

Coordination of benefits applies when you have more than one 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.

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 non-medical 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 participating provider will forward your coverage information to us. If you have a nonparticipating provider, you are responsible for informing us about your other coverage.

Coordination with Group MedicareBlue Rx

If you are a member of the Retired/Disabled group and you are enrolled in the Group MedicareBlue Rx prescription drug plan, the benefits of your Group MedicareBlue Rx prescription drug plan are primary for prescription drugs purchased at the pharmacy; although the benefits of your Group MedicareBlue Rx prescription drug plan are primary, you will continue to pay the copayment or coinsurance you have always paid under your State of Iowa prescription drug plan.

The benefits of your Group MedicareBlue Rx prescription drug plan are primary for prescription drugs purchased at the pharmacy and you should present your

Group MedicareBlue Rx ID card to the pharmacy as the primary payer. The benefits of your Blue Rx Complete prescription drug plan are secondary for prescription drugs purchased at the pharmacy and you should present your Blue Rx Complete ID card to the pharmacy as the secondary payer. You will be required to pay the same copayment or coinsurance amounts that would otherwise apply if you did not have Group MedicareBlue Rx.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services, 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. 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 (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan

does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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.

If none of these rules apply to your situation, we will follow the Iowa Insurance Division's Coordination of Benefits guidelines to determine this health plan payment.

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.

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.

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 employer group health coverage under this medical benefits plan and your employer has the required minimum number of employees.

However, if you are eligible for Medicare either as a retiree or a spouse of a retiree or because of your or your spouse's disability status, your benefits under this medical benefits plan will be coordinated with benefits available under Medicare Part B, even if you or your spouse are not enrolled in Medicare Part B.

If you are no longer actively working, Medicare will be primary. Therefore, any member enrolled in Medicare Part A should also consider enrolling in Part B, as Retiree benefits under this plan will be reduced by the amount that would have been covered by Medicare Part B.

Medicare's Payment vs. This Plan's Payment
Medicare's allowed amount for a service may be different than our allowed amount (our allowed amount is also referred to as our "maximum allowable fee") for that same service. When Medicare is primary, and Medicare's allowed amount for a service is greater than our allowed amount for that same service, we will reimburse up to our allowed amount for the service. You may be responsible for any difference between Medicare's allowed amount and our allowed amount.

Working Aged
Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled
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 an employer group health plan.

End-Stage Renal Disease (ESRD)
Under ESRD requirements, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- The beneficiary has Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer 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 covered for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws, which may change from time to time. For

more information, contact your employer 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 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 63.

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 Blue Cross and Blue Shield of Iowa
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.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 33.

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.state.ia.us*.

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
Two Ruan Center
601 Locust, 4th Floor
Des Moines, IA 50309-3738
Fax: 515-281-3059
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 experimental or investigational 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.

Legal Action

You shall not start legal action against us until you have exhausted the appeal procedure described in this section.

13. 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 employer or group sponsor.
- Any agreement or group policy we have with your employer or group sponsor.
- Any application completed by your employer or group sponsor.
- This benefit booklet and any riders or amendments.

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

Interpreting this Benefit Booklet

We will interpret the provisions of this benefit booklet 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 benefit booklet. If any benefit described in this benefit booklet 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.

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

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this benefit booklet at any time. Any amendment or modification will be in writing and will be as binding as this benefit booklet. 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 benefit booklet. This benefit booklet cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your employer or 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 47.

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

You have agreed in your application (or in documents kept by us or your employer or group sponsor) 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 in your application, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application, then we may terminate your coverage under this group health plan.

Privacy of Information

Your employer or 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 employer or 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 employer or 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 employer or 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.

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. Examples include 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.

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, 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 members. Your claims information may be used by the value-based program and any providers involved in such value-based program.

Nonassignment

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. You are prohibited from assigning any claim or cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan or rights to payment will be void.

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. 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.

Legal Action

You shall not start any legal action against us unless you have exhausted the applicable appeal process and the external review process described in the *Appeals* section.

You shall not bring any legal or equitable action against us because of a claim under this group health 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.

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 pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for benefits under Medicaid will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of benefits.

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 participating 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

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 employer or 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 are injured as a result of the act of a third party 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 injury from money received from the third party or its insurer, 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 of the following:

- The responsible person or that person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage, including but not limited to homeowner's, motor vehicle, or medical payments insurance.

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 non-medical 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 were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such 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 injury, 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 Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 5E151
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 benefits 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 of benefits paid under this plan from your employer, your employer's workers' compensation carrier, or you 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.

Notice

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

Wellmark Blue Cross and Blue Shield of Iowa
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.

Glossary

The definitions in this section are terms that are used in various sections of this benefit booklet. 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, 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 and Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of participating Network providers throughout the United States.

Creditable Coverage. Any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

- 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 an affidavit of domestic partnership with the plan member.

Group. Those plan members who share a common relationship, such as employment or membership.

Group Sponsor. The entity that sponsors this group health plan.

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.

Medically Urgent Situation. A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits plan member seeking services or, in the 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 Provider. A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, or the home.

Participating Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield Plan.

Plan Member. The person who signed for this group health plan.

Plan Year. A date used for purposes of determining compliance with federal legislation.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this benefit booklet, that may be used to diagnose or treat a medical condition.

Spouse. A man or woman lawfully married to a covered member under any state law (or the law of any U.S. territory or possession or any foreign jurisdiction with legal authority to sanction marriages), including common law marriage, regardless of where the couple lives.

We, Our, Us. Wellmark Blue Cross and Blue Shield of Iowa.

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.

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