Wellmark Health Plan of Iowa

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

State of Iowa
Iowa Choice

Blue Access / Blue Rx Complete Prescription Drug Plan

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

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

For Precertification: 800-558-4409

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State of Iowa Iowa Choice Access HMO
U65 Access HMO
O65 Access HMO
Cobra Access HMO

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.

Contents

About This Benefit Booklet 1

1. What You Pay 3
- Payment Summary 4
- Payment Details 5

2. At a Glance - Covered and Not Covered 13
- Iowa Choice 13
- Prescription Drugs 16

3. Details - Covered and Not Covered 17
- Iowa Choice 17
- Prescription Drugs 34

4. General Conditions of Coverage, Exclusions, and Limitations 39
- Conditions of Coverage 39
- General Exclusions 40
- Benefit Limitations 42

5. Choosing a Provider 43
- Iowa Choice 43
- Prescription Drugs 49

6. Notification Requirements and Care Coordination 51
- Iowa Choice 51
- Prescription Drugs 55

7. Factors Affecting What You Pay 57
- Iowa Choice 57
- Prescription Drugs 60

8. Coverage Eligibility and Effective Date 65
- Eligible Members 65
- When Coverage Begins 66
- Late Enrollees 66
- Changes to Information Related to You or to Your Benefits 66
- Qualified Medical Child Support Order 66

9. Coverage Changes and Termination 69
- Coverage Change Events 69
- Requirement to Notify Group Sponsor 69
- Coverage Termination 70
- Coverage Continuation 71

10. Claims 73
- When to File a Claim 73
- How to File a Claim 73
- Notification of Decision 74

11. Coordination of Benefits 77
- Other Coverage 77
- Claim Filing 78
- Rules of Coordination 78
- Coordination with Medicare 81

12. Appeals 83
Right of Appeal 83
How to Request an Internal Appeal 83
Where to Send Internal Appeal 83
Review of Internal Appeal 83
Decision on Internal Appeal 84
External Review 84
Arbitration and Legal Action 85
13. Arbitration and Legal Action 87
Mandatory Arbitration 87
Covered Claims 87
No Class Arbitrations and Class Actions Waiver 87
Claims Excluded from Mandatory Arbitration 87
Arbitration Process Generally 88
Arbitration Fees and Other Costs 89
Confidentiality 89
Questions of Arbitrability 89
Claims Excluded By Applicable Law 89
Survival and Severability of Terms 89
14. General Provisions 91
Contract 91
Interpreting this Benefit Booklet 91
Plan Year 91
Authority to Terminate, Amend, or Modify 91
Authorized Group Benefits Plan Changes 91
Member Participation 91
Authorized Representative 91
Release of Information 92
Privacy of Information 92
Member Health Support Services 93
Value Added or Innovative Benefits 93
Value-Based Programs 93
Nonassignment 93
Governing Law 93
Medicaid Enrollment and Payments to Medicaid 94
Subrogation 94
Workers' Compensation 96
Payment in Error 96
Notice 97
Inspection of Coverage 97
Submitting a Complaint 97
Consent to Telephone Calls and Text or Email Notifications 97
Glossary 99
Index 103

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.

This group health plan consists of medical benefits and prescription drug benefits. Your Wellmark Health Plan of Iowa, Inc., (Wellmark) benefits are called Blue Access. The prescription drug benefits are called Blue Rx Complete. This benefit booklet will indicate when the service, supply or drug is considered medical benefits or drug benefits by using sections, headings, and notes when necessary.

Charts

Some sections have charts, which provide a quick reference or summary but are not a complete description of all details about a topic. A particular chart may not describe some significant factors that would help determine your coverage, payments, or other responsibilities. It is important for you to look up details and not to rely only upon a chart. It is also important to follow any references to other parts of the 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.

Provider Network

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

Generally, you are only covered for services received from Wellmark Blue HMO Providers; however, you may be covered for services received from Participating Providers only in the case of an emergency, accidental injury, guest membership, or approved referrals. You may be covered for services received from Out-of-Network Providers in the case of an emergency, accidental injury, or approved Out-of-Network referrals.

Wellmark Blue HMO Providers. These providers participate with the Wellmark Blue HMO network. Throughout this benefit booklet we will refer to these providers as "Network" Providers. Benefits for most covered services are available only when received from Wellmark Blue HMO Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with the Wellmark Blue HMO network. Generally, you are only covered for services received from Participating Providers in case of emergency, accidental injury, guest membership, or approved referrals.

Out-of-Network Providers. Out-of-Network Providers do not participate with the Wellmark Blue HMO network or any other Blue Cross and/or Blue Shield Plan. Generally, you are only covered for services received from Out-of-Network Providers in case of emergency, accidental injury, or approved Out-of-Network referrals.

Iowa Choice

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.

You Pay
Deductible **$250** per person **$500** (maximum) per family*
Emergency Room Copayment **$100**
Office Visit Copayment **$15** for: ■ covered services received from Network primary care providers ■ covered services received from Network chiropractors ■ covered services received from Network occupational therapists ■ covered services received from Network physical therapists ■ covered services received from Network speech pathologists ■ covered mental health and chemical dependency treatment received in an office setting from any Network Provider **$30** for covered services received from Network non-primary care providers.
Telehealth Services Copayment **$10** for covered telehealth services received from practitioners contracting through Doctor on Demand§. **$15** for: ■ covered telehealth services received from Network primary care providers ■ covered telehealth services received from Network chiropractors ■ covered telehealth services received from Network occupational therapists ■ covered telehealth services received from Network physical therapists ■ covered telehealth services received from Network speech pathologists ■ covered telehealth mental health and chemical dependency treatment received from any Network Provider **$30** for covered telehealth services received from Network non-primary care providers.
Urgent Care Center Copayment **$15** for covered services received from Network Providers in Iowa classified by Wellmark as Urgent Care Centers.†
Coinsurance **10%**
Out-of-Pocket Maximum **$1,000** per person **$2,000** (maximum) per family*

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.
†For a list of Iowa facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.
§Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

Prescription Drugs

You Pay†
Copayment **$10** for Tier 1 medications. **$25** for Tier 2 medications. **$50** for Tier 3 and 4 medications. For more information see *Tiers*, page 61. **$100** for preferred specialty drugs. **$200** for non-preferred specialty drugs.
Out-of-Pocket Maximum **$5,850** per person **$11,700** (maximum) per family*

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members.
†You pay the entire cost if you purchase a drug that is not on the Wellmark Blue Rx Complete Drug List. See Wellmark Blue Rx Complete Drug List, page 34.

Prescription Maximums

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

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

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

Payment Details

Iowa Choice

Deductible

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

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

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

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. These credits do not apply toward your out-of-pocket maximum.

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.

Copayment

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

Emergency Room Copayment.

The emergency room copayment:

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

Office Visit Copayment.

The office visit copayment:

- applies to covered office services.
- is taken once per practitioner per date of service.

Please note: For purposes of determining your copayment responsibility, Network Providers are classified by Wellmark as either primary care providers or non-primary care providers. To determine whether the primary care provider copayment or the non-primary care provider copayment applies, you should call the Customer Service number on your ID card before receiving any services to determine whether your provider is classified by Wellmark as a primary care provider or a non-primary care provider for purposes of your copayment responsibility.

How providers are classified in the Wellmark Provider Directory does not determine whether a provider is a primary care provider or a non-primary care provider for purposes of your copayment responsibility. For example, a provider might be listed under multiple specialties in the provider directory, such as internal medicine and oncology, but would be classified by Wellmark as a primary care provider for purposes of your copayment responsibility.

A primary care provider is a Network:

- advanced registered nurse practitioner (ARNP)
- family practitioner
- general practitioner
- internal medicine practitioner
- obstetrician/gynecologist
- pediatrician
- physician assistant (PA)

All other Network Providers are non-primary care providers. See *Choosing a Provider*, page 43.

Telehealth Services Copayment.

The telehealth services copayment:

- applies to covered telehealth services received from Network practitioners and practitioners contracting through Doctor on Demand.
- is taken once per practitioner per date of service.

Please note: For purposes of determining your copayment responsibility, Network Providers are classified by Wellmark as either primary care providers or non-primary care providers. To determine whether the primary care provider

copayment or the non-primary care provider copayment applies, you should call the Customer Service number on your ID card before receiving any services to determine whether your provider is classified by Wellmark as a primary care provider or a non-primary care provider for purposes of your copayment responsibility. Doctor on Demand is not a Network Provider, so will apply a separate copayment responsibility.

How providers are classified in the Wellmark Provider Directory does not determine whether a provider is a primary care provider or a non-primary care provider for purposes of your copayment responsibility. For example, a provider might be listed under multiple specialties in the provider directory, such as internal medicine and oncology, but would be classified by Wellmark as a primary care provider for purposes of your copayment responsibility.

A primary care provider is a Network:

- advanced registered nurse practitioner (ARNP)
- family practitioner
- general practitioner
- internal medicine practitioner
- obstetrician/gynecologist
- pediatrician
- physician assistant (PA)

All other Network Providers are non-primary care providers. See *Choosing a Provider*, page 43.

Urgent Care Center Copayment.

The urgent care center copayment:

- applies to covered urgent care services received from:
  - Network Providers in Iowa classified by Wellmark as Urgent Care Centers.
- is taken once per provider per date of service.

Please note: If you receive care at a facility in Iowa that is not classified by Wellmark as an Urgent Care Center, you may be responsible for your deductible and coinsurance (as applicable) instead of the urgent care center copayment. Therefore, before receiving any urgent care services, you should determine if the facility is classified by Wellmark as an Urgent Care Center. See the Wellmark Provider Directory at *Wellmark.com* or call the Customer Service number on your ID card to determine whether a facility is classified by Wellmark as an Urgent Care Center.

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

Coinsurance

Coinsurance is an amount you pay for certain covered services. Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance is Calculated*, page 57. 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.
- Emergency room copayments.
- Office visit copayments.
- Telehealth services copayments.
- Urgent care center copayments.

The family out-of-pocket maximum is reached from applicable amounts paid on

behalf of any combination of covered family members.

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 39.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

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

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 Health Plan of Iowa, Inc.

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Breast pumps (manual or non-hospital grade electric) purchased from a covered home/durable medical equipment provider.	Deductible Coinsurance Copayment
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding.	Deductible Coinsurance Copayment
Contraceptive medical devices, such as intrauterine devices and diaphragms.	Deductible Coinsurance Copayment
Implanted and injected contraceptives.	Deductible Coinsurance Copayment
Independent laboratory services.	Deductible Copayment
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.	Deductible Coinsurance Copayment
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services.	Deductible

Covered Service	Payment Obligation Waived
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
Preventive care, items, and services* 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 (ACIP); ■ Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and ■ Preventive care and screenings for women provided for in guidelines supported by the HRSA.	Deductible Coinsurance Copayment
Preventive digital breast tomosynthesis (3D mammogram).	Deductible Coinsurance Copayment
Preventive prostate-specific antigen (PSA) testing.	Deductible Coinsurance Copayment
Prosthetic limb devices.	Deductible
Services subject to emergency room copayment amounts.	Deductible Coinsurance
Services subject to office visit copayment amounts.	Deductible Coinsurance
Services subject to telehealth services copayment amounts.‡	Deductible Coinsurance
Services subject to urgent care center copayment amounts.	Deductible Coinsurance
Voluntary sterilization for female members.	Deductible Coinsurance Copayment

Covered Service	Payment Obligation Waived
X-ray and lab services billed by Network facilities and interpretations by Network practitioners when your practitioner sends you to the outpatient department of a Network facility. The deductible is not waived for the following diagnostic imaging/studies and radiation therapy services including, but not limited to: CT (computerized tomography), MEG (magnetoencephalography), MRAs (magnetic resonance angiography), MRIs (magnetic resonance imaging), PET (positron emission tomography), nuclear medicine, ultrasounds, radiation therapy, diagnostic mammograms, and diagnostic testing.	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 benefits for the newborn during the first 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If that occurs, a separate deductible and coinsurance may be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child.

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

Prescription Drugs

Copayment

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled.

You pay the entire cost if you purchase a drug that is not on the Wellmark Blue Rx Complete Drug List. See *Wellmark Blue Rx Complete Drug List,* page 34.

Out-of-Pocket Maximum

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

- Copayments.

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

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 39.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved “A”-rated medically appropriate generic equivalent.

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

Waived Payment Obligations

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

Covered Drug or Service	Payment Obligation Waived
Generic contraceptive drugs and generic contraceptive drug delivery devices (e.g., birth control patches). Payment obligations are also waived if you purchase brand name contraceptive drugs or brand name drug delivery devices when an FDA-approved medically appropriate generic equivalent is not available. Payment obligations are not waived if you purchase brand name contraceptive drugs or brand name contraceptive drug delivery devices when an FDA-approved medically appropriate generic equivalent is available.	Copayment
Preventive items or services* as follows: ■ Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); and ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).	Copayment
Two smoking cessation attempts per calendar year, up to a 90-days' supply of covered drugs for each attempt, or a 180-days' supply total per calendar year.	Copayment

*A complete list of recommendations and guidelines related to preventive services can be found at *www.healthcare.gov*. Recommended preventive items and services are subject to change and are subject to medical management.

2. At a Glance - Covered and Not Covered

Iowa Choice

Your coverage provides benefits for many services and supplies received from Network Providers. 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 17. 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 Health Plan of Iowa, Inc.

Category	Covered	Not Covered	See Page	Benefits Maximums
Acupuncture Treatment		⊘	17	
Allergy Testing and Treatment	●		17	
Ambulance Services	●		17	
Anesthesia	●		17	
Autism Treatment	●		18	
Blood and Blood Administration	●		18	
Chemical Dependency Treatment	●		18	
Chemotherapy and Radiation Therapy	●		19	
Clinical Trials – Routine Care Associated with Clinical Trials	●		19	
Contraceptives	●		19	
Conversion Therapy		⊘	20	
Cosmetic Services		⊘	20	

Category	Covered	Not Covered	See Page	Benefits Maximums
Counseling and Education Services		⦸	20	
Dental Treatment for Accidental Injury	●		20	
Dialysis	●		21	
Education Services for Diabetes and Nutrition	●		21	10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to two hours annually.
Emergency Services	●		21	
Fertility and Infertility Services	●		22	$25,000 per lifetime for infertility transfer procedures and the collection, purchase, and cryopreservation of semen (sperm), oocytes (eggs), or embryo.
Genetic Testing	●		22	
Hearing Services	●		22	One routine hearing examination per benefit year.
Home Health Services	●		22	The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		23	
Hospice Services	●		24	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	●		24	
Illness or Injury Services	●		24	
Inhalation Therapy	●		25	
Maternity Services	●		25	
Medical and Surgical Supplies and Personal Convenience Items	●		25	
Mental Health Services	●		26	
Morbid Obesity Treatment	●		27	
Motor Vehicles		⦸	27	
Musculoskeletal Treatment	●		27	
Nonmedical or Administrative Services		⦸	27	
Nutritional and Dietary Supplements	●		28	
Occupational Therapy	●		28	
Orthotics		⦸	28	

Category	Covered	Not Covered	See Page	Benefits Maximums
Physical Therapy	●		28	
Physicians and Practitioners			29	
Advanced Registered Nurse Practitioners	●		29	
Audiologists	●		29	
Chiropractors	●		29	
Doctors of Osteopathy	●		29	
Licensed Independent Social Workers	●		29	
Medical Doctors	●		29	
Occupational Therapists	●		29	
Optometrists	●		29	
Oral Surgeons	●		29	
Physical Therapists	●		29	
Physician Assistants	●		29	
Podiatrists	●		29	
Psychologists	●		29	
Speech Pathologists	●		29	
Prescription Drugs	●		29	
Preventive Care	●		30	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year. One routine Pap smear per benefit year.
Prosthetic Devices	●		31	
Reconstructive Surgery	●		32	
Self-Help Programs		⦸	32	
Sleep Apnea Treatment	●		32	
Social Adjustment		⦸	32	
Speech Therapy	●		32	
Surgery	●		32	
Telehealth Services	●		32	
Temporomandibular Joint Disorder (TMD)	●		33	
Transplants	●		33	
Travel or Lodging Costs		⦸	33	
Vision Services	●		33	One routine vision examination per benefit year.
Wigs or Hairpieces		⦸	33	
X-ray and Laboratory Services	●		34	

Prescription Drugs

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

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

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this benefit booklet. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 39. If a service or supply is not specifically listed, do not assume it is covered.

Iowa Choice

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered:

- Professional emergency air and ground ambulance transportation to a hospital 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 in the Wellmark Blue HMO network with adequate facilities to treat your medical condition. In an emergency situation, you should seek care at the nearest appropriate facility, whether the facility is in-network or out-of-network.

  — During transport, your medical condition requires the services that are provided only by an air or ground ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility in an emergency.

  — The air or ground ambulance has the necessary patient care equipment and supplies to meet your needs.

  — Your medical condition requires immediate and rapid ambulance transport.

  — In addition to the preceding requirements, for air ambulance services to be covered, all of the following must be met:

    - Your medical condition requires immediate and rapid air 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.

  In an emergency situation, if you cannot reasonably utilize a Network ambulance service, covered services will be reimbursed as though they were received from a Network ambulance service. However, because we do not have contracts with Out-of-Network 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.

- Professional nonemergency 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.

— You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

— During transport your medical condition requires the services that are provided only by a ground ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility.

— The ground ambulance has the necessary patient care equipment and supplies to meet your needs.

Not Covered:

- Professional air or ground ambulance transport from a facility capable of treating your condition.
- Professional ground ambulance transport to or from any location when you are physically and mentally capable of being a passenger in a private vehicle.
- Professional ground ambulance round-trip transports from your residence to a medical provider for an appointment or treatment and back to your residence.
- Professional air or ground transport when performed primarily for your convenience or the convenience of your family, physician, or other health care provider.
- Professional, nonemergency air ambulance transports to any location for any reason.
- Nonprofessional air or ground ambulance transports to any location for any reason. This includes non-ambulance vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder. Autism spectrum disorder is a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior.

Not Covered:

- Applied Behavior Analysis services for the treatment of autism spectrum disorder for members age 21 and older.
- Applied Behavior Analysis services other than for the treatment of autism spectrum disorder.

Blood and Blood Administration

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

Chemical Dependency Treatment

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

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

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

Not Covered:

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

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 51.

Chemotherapy and Radiation Therapy

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

Clinical Trials – Routine Care Associated with Clinical Trials

Covered: Medically necessary routine patient costs for items and services otherwise covered under this plan furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when a covered member is referred by a Network Provider based on the conclusion that the member is eligible to participate in an approved clinical trial according to the trial protocol or the member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate according to the trial protocol.

Not Covered:

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

Contraceptives

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

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

Please note: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches are covered

under your Blue Rx Complete prescription drug benefits described later in this section.

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

Conversion Therapy

Not Covered: Conversion therapy services.

Cosmetic Services

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

See Also:

Reconstructive Surgery later in this section.

Counseling and Education Services

Not Covered:

- Bereavement counseling or services (including volunteers or clergy), family counseling or training services, marriage counseling or training services, and community-based services.
- Education or educational therapy other than covered lactation consultant services, education for self-management of diabetes, or nutrition education.
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for the treatment of obesity, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia, for any medical, mental health, or substance abuse condition.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes and Nutrition later in this section.

Mental Health Services later in this section.

Preventive Care later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries.
- 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 inpatient or outpatient of a facility only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Orthodontic services associated with management of cleft palate.
- Treatment of abnormal changes in the mouth due to disease of the mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination

of oral infection) required for the direct treatment of a medical condition, limited to:
  - Dental services related to medical transplant procedures;
  - Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); or
  - Treatment of neoplasms of the mouth and contiguous tissue.

Not Covered:

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

Dialysis

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

Education Services for Diabetes and Nutrition

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

All covered training or education must be prescribed by a licensed physician. Outpatient training or education must be provided by a state-certified program.

The state-certified diabetic education program helps any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.

You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your nutritional requirements. Nutrition education is appropriate for, but not limited to:

- Eating disorders.
- Glucose intolerance.
- High blood pressure.
- Lactose intolerance.
- Morbid obesity.

Benefits Maximum:

- **10 hours** of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to two hours annually.

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 Network Provider, covered services will be reimbursed as though they were received from a Network Provider. However, because we do not have contracts with Out-of-Network 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:

Out-of-Network Providers, page 59.

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, purchase, and cryopreservation of semen (sperm), oocytes (eggs), or embryo.

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.

Genetic Testing

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

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

Hearing Services

Covered:

- Routine hearing examinations.

Benefits Maximum:

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

Not Covered:

- Hearing aids.

Home Health Services

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

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

The following are covered services and supplies:

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

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

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

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

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered:

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

See Also:

Referrals, page 43.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- The equipment is ordered by a provider within the scope of his or her license and there is a written prescription.
- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.
- Standard or basic home/durable medical equipment that will adequately meet the medical needs and that does not have certain deluxe/luxury or convenience upgrade or add-on features.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

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

Orthotics later in this section.

Prosthetic Devices later in this section.

Referrals, page 43.

Hospice Services

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

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

Benefits Maximum:

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

Hospitals and Facilities

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

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

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

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

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

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

Psychiatric Medical Institution for Children (PMIC). This type of facility provides inpatient psychiatric services to children and is licensed as a PMIC under Iowa Code Chapter 135H.

Precertification is required. For information on how to precertify, refer to *Precertification* in the *Notification Requirements and Care Coordination* section of this benefit booklet, or call the Customer Service number on your ID card.

Not Covered:

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

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illness or Injury Services

Covered:

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.

- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.

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

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

Not Covered:

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

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 benefits for the newborn during the first 48 hours following a vaginal delivery or 96 hours following a cesarean delivery. If that occurs, a separate deductible and coinsurance may be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child.

See Also:

Coverage Change Events, page 69.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

- Dressings and casts.

- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies including insulin syringes purchased from a covered home/durable medical equipment provider.

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

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

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Prescription Drugs, page 34.

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.

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

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

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

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Individual, group, or family therapy provided in a clinically managed low

intensity residential treatment setting, also known as supervised living;

- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Psychiatric observation;
- Care provided in a psychiatric residential crisis program;
- Care provided in a medically monitored intensive inpatient setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

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: Treatment for:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders.
- Conditions that are not pervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual disorders.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:

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

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.

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 or Administrative Services

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

Nutritional and Dietary Supplements

Covered:

- Nutritional and dietary supplements prescribed by a physician for permanent inborn errors of metabolism, such as PKU.
- Enteral and nutritional therapy only when prescribed feeding is administered through a feeding tube, except for permanent inborn errors of metabolism.

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

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

Occupational Therapy

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

- Services are to treat the upper extremities, which means the arms from the shoulders to the fingers.
- The goal of the occupational therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation 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

Covered: Orthotics training.

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

See Also:

Home/Durable Medical Equipment earlier in this section.

Prosthetic Devices later in this section.

Physical Therapy

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

- The goal of the physical therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation 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 43.

Prescription Drugs

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

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

Prescription drugs and medicines covered under your medical benefits include:

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

Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

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

Specialty drugs may be covered under your medical benefits or under your Blue Rx Complete prescription drug benefits. If a specialty drug that is covered under your medical benefits is not provided by your physician, we recommend that you purchase specialty drugs through a participating pharmacy or through the specialty pharmacy program. To determine whether a particular specialty drug is covered

under your medical benefits or under your Blue Rx Complete prescription drug benefits, consult the Wellmark Blue Rx Complete Drug List at *Wellmark.com*, or call the Customer Service number on your ID card. See *Specialty Pharmacy Program*, page 50.

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

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

- Antigen therapy.
- Medication Therapy Management (MTM) when billed separately.
- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.
- Prescription drugs that are not FDA-approved.

Some prescription drugs are covered under your Blue Rx Complete benefits:

- Insulin.

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

See Also:

Contraceptives earlier in this section.

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

Notification Requirements and Care Coordination, page 51.

Prescription Drugs later in this section.

Prior Authorization, page 55.

Preventive Care

Covered: Preventive care such as:

- Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- Digital breast tomosynthesis (3D mammogram).
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
  - Items or services with an “A” or “B” rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
  - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
  - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric

preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

To qualify for benefits, you must receive preventive care from providers listed in your provider directory under any of the following categories:

- Advanced registered nurse practitioner (ARNP).
- Family Practice/General Practice.
- Internal Medicine.
- Pediatrics and Obstetrics/Gynecology.
- Physician Assistant (PA).

However, you may also receive covered immunizations from Network Public Health Agencies or Network Visiting Nurse Associations.

Benefits Maximum:

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

Please note: Physical examination limits do not include items or services with an "A" or "B" rating in the current recommendations of the USPSTF, immunizations as recommended by ACIP, and preventive care and screening guidelines supported by the HRSA, as described under *Covered*.

Not Covered:

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

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

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

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

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.

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

Orthotics earlier in this section.

Referrals, page 43.

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.

Social Adjustment

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

Speech Therapy

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

Not Covered:

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

Surgery

Covered. This includes the following:

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

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

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

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

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

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Covered:

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

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

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

See Also:

Ambulance Services earlier in this section.

Case Management, page 55.

Referrals, page 43.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered:

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

Benefits Maximum:

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

Not Covered:

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

Wigs or Hairpieces

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.

Prescription Drugs

Guidelines for Drug Coverage

To be covered, a prescription drug must meet all of the following criteria:

- Listed on the Wellmark Blue Rx Complete Drug List.
- Can be legally obtained in the United States only with a written prescription.
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962.
- Prescribed by a practitioner prescribing within the scope of his or her license.
- Dispensed by a recognized licensed retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program, through the mail order drug program, or dispensed and billed by a hospital or other facility as a take-home drug for a short-term supply.
- Medically necessary for your condition. See *Medically Necessary*, page 39.
- Not available in an equivalent over-the-counter strength. However, certain over-the-counter products and over-the-counter nicotine dependency drugs prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.
- Reviewed, evaluated, and recommended for addition to the Wellmark Blue Rx Complete Drug List by Wellmark.

Drugs that are Covered

The Wellmark Blue Rx Complete Drug List

The Wellmark Blue Rx Complete Drug List is a reference list that includes generic and brand-name prescription drugs that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Complete prescription drug benefits. The Drug List is updated on a quarterly basis, or when new drugs become available, and as discontinued drugs are removed from the marketplace.

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

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card and request a copy of the Drug List.

Drugs will not be added to or removed from the Drug List until they have been evaluated by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is a group of practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety and effectiveness of new and existing medications and make any necessary changes to the Drug List.

The Drug List is subject to change.

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

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

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

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

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

Limits on Prescription Drug Coverage

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

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

Drugs, Services, and Items that are Not Covered

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

- Drugs not listed on the Wellmark Blue Rx Complete Drug List.
- Drugs in excess of a quantity limitation. See *Quantity Limitations* later in this section.
- Antigen therapy.
- Drugs that are not FDA-approved.
- Investigational or experimental drugs.
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain.
- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug.
- Drugs determined to be abused or otherwise misused by you.

- Drugs that are lost, damaged, stolen, or used inappropriately.
- Contraceptive medical devices, such as intrauterine devices and diaphragms. These are covered under your medical benefits. See *Contraceptives*, page 19.
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.
- Cosmetic drugs.
- Infused drugs. These may be covered under your medical benefits. See *Specialty Drugs*, page 29.
- Irrigation solutions and supplies.
- Medication Therapy Management (MTM) when billed separately.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Weight reduction drugs.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

See Also:

Prescription Drugs, page 29.

Prescription Purchases Outside the United States

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

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same name and dosage form as the FDA-approved drug's active ingredient.
- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

Quantity Limitations

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

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

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

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

Refills

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

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

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time.

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

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

4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

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

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Nationally recognized utilization management standards as utilized by Wellmark; or
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

If you receive services that are not medically necessary, you are responsible for the cost if:

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a Network or Participating provider and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be not medically necessary; and
  - The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

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

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

Member Eligibility
Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 65.

General Exclusions

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

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

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

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

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

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

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a Network or Participating provider and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and
  - The provider gives you a written estimate of the cost for such services and you agree in writing, before

receiving the services, to assume the payment responsibility.

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

- You are also responsible for the cost if you receive services from a provider outside of the Network 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 19.

Complications of a Noncovered Service

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

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

Nonmedical or Administrative Services

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

Provider Is Family Member

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

Covered by Other Programs or Laws

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

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

Workers' Compensation

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

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

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

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

Benefit Limitations

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

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered,* page 17.
- 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 8, and *At a Glance–Covered and Not Covered*, page 13.
- If you do not obtain precertification for certain medical services, benefits can be denied. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A Network Provider in the Wellmark Blue HMO network will handle notification requirements for you. If you see a provider outside the Wellmark Blue HMO network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 51.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

  You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A Network Provider in the Wellmark Blue HMO network will handle notification requirements for you. If you see a provider outside the Wellmark Blue HMO network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 51.
- If you do not obtain prior authorization for certain prescription drugs, benefits can be denied. See *Notification Requirements and Care Coordination*, page 51.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 43, and *Factors Affecting What You Pay*, page 57. An example of a charge that depends on the type of provider includes, but is not limited to:
  - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network practitioner.

5. Choosing a Provider

Provider Network

Under the medical benefits of this plan, your network of providers consists of Wellmark Blue HMO Providers. All other providers are not in your network.

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

With Blue Access, benefits for most covered services are available only when received from Network Providers.

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

Providers are independent contractors and are not agents or employees of Wellmark Health Plan of Iowa, Inc. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 24 and *Physicians and Practitioners*, page 29.

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

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

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

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

Referrals

If there are no providers in the Wellmark Blue HMO network who can treat your condition, you will be referred to a provider outside the Wellmark Blue HMO network who has expertise in diagnosing and treating your condition. Wellmark must approve referrals outside of the Wellmark Blue HMO network before you receive services or the services will not be covered. **Please note:** Even when your referral outside the Wellmark Blue HMO network is approved, you are still responsible for complying with notification requirements. See *Notification Requirements and Care Coordination*, page 51. **Please note:** Even when your referral outside the Wellmark Blue HMO network is approved, you may be responsible for the difference between the

amount an Out-of-Network Provider bills and our payment amount.

Services Outside the Wellmark Blue HMO Network

BlueCard Program

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

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

In an emergency situation, seek care at the nearest hospital emergency room. Whenever possible, before receiving services outside the Wellmark Blue HMO network, you should always ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate Participating Providers in any state, call **800-810-BLUE**, or visit *www.bcbs.com*.

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

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

Typically, when you receive covered services from Participating Providers outside the Wellmark Blue HMO network, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 51. However, if you are admitted to a BlueCard facility outside the Wellmark Blue HMO network, any Participating Provider should handle notification requirements for you.

Wellmark Health Plan of Iowa, Inc., is an affiliate of Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa, independent licensees of the Blue Cross Blue Shield Association. We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside the Wellmark Blue HMO network, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of our service area, you will receive it from one of two

kinds of providers. Most providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("Out-of-Network Providers") don't contract with the Host Blue. In the following paragraphs we explain how we pay both kinds of providers.

We cover only limited healthcare services received outside of our service area. As used in this section, "out-of-area covered services" include accidental injuries, emergencies, continuity of care, out-of-network referrals, and Guest Membership obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by us.

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

The BlueCard Program enables you to obtain covered out-of-area services, as defined previously in this section, from a healthcare provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the covered out-of-area services provided to you, so there are no claim forms for you to fill out. You will be responsible for your payment obligations. See *Referrals* earlier in this section. In addition notification requirements may apply, See *Notification Requirements and Care Coordination*, page 51

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

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

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

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

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

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

Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or

other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside the Wellmark Service Area

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

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

Change of Residence

You must notify us prior to relocating outside the Wellmark Health Plan of Iowa, Inc., geographic service area because you will have no benefits for medical or laboratory services provided outside of Wellmark Health Plan of Iowa, Inc.'s provider network except for emergencies or accidental injuries.

Care in a Foreign Country

For covered services you receive in a country other than the United States, payment level assumes the provider category is Out-of-Network except for services received from providers that participate with Blue Cross Blue Shield Global Core. You are only covered for emergency care or care for an accidental injury when you receive care in a foreign country.

Blue Cross Blue Shield Global® Core Program

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

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

Inpatient Services. In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service

Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. **You must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 73.

Submitting a Blue Cross Blue Shield Global Core Claim

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

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

- **Accidental Injuries.**
- **Emergencies.**

If you are unable to reach a Network Provider, it is usually to your advantage to receive services from a Participating Provider. Participating Providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with the Wellmark Blue HMO network.

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

For information on how benefits for accidental injuries and emergency services will be administered when received outside of the Wellmark Blue HMO network, see *BlueCard Program* earlier in this section and *Out-of-Network Providers*, page 59.

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

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

- **Continuity of Care.** You may be eligible to continue care from an Out-of-Network Provider for treatment of a terminal illness, a complex medical condition, or during the second or third trimester of pregnancy if:
  — You had been receiving care for the condition from a Network Provider but the provider's contract with us terminates; or
  — You were previously covered by a different carrier or plan and had been receiving care for the condition

from an Out-of-Network Provider when you begin coverage under your medical benefits.

If either situation applies, you may continue Out-of-Network treatment as follows:

— Terminal illness (as determined by the provider): for 90 days after the provider's contract terminates or the patient begins coverage with Wellmark while under the care of an Out-of-Network Provider for treatment of the terminal illness, whichever applies.

— Complex medical condition: for a time period or benefit maximum determined by medical management. You or your provider must notify us before receiving services under these medical benefits, and the medical condition must warrant continued treatment by the Out-of-Network Provider.

— Pregnancy in second or third trimester: through postpartum care related to the childbirth and delivery.

To assist you in making a transition to a Network Provider, you or your provider must call us at **800-552-3993**.

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

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

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

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

Laboratory services. You may have laboratory specimens or samples collected by a Network 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, the service will not be covered and you will be responsible for the entire amount charged.

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, the service will not be covered and you will be responsible for the entire amount charged.

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, the service will not be covered and you will be responsible for the entire amount charged. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in the Wellmark Blue HMO network, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

Prosthetic devices. If you purchase prosthetic devices from a provider that does not have a contractual relationship with the Blue Plan where you purchased the prosthetic devices, the service will not be covered and you will be responsible for the entire amount charged.

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, the service will not be covered and you will be

responsible for the entire amount charged. This includes situations where you purchase prosthetic devices and have them shipped to you in the Wellmark Blue HMO network, when Wellmark does not have a contractual relationship with the provider.

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

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

See *Out-of-Network Providers,* page 59.

Prescription Drugs

Choosing a Pharmacy

Your prescription drug benefits are called Blue Rx Complete. Pharmacies that participate with the network used by Blue Rx Complete are called participating pharmacies. Pharmacies that do not participate with the network are called nonparticipating pharmacies.

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

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

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

Advantages of Visiting Participating Pharmacies

When you fill your prescription at participating pharmacies:

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

Always Present Your ID Card

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

- You must pay the full amount charged at the time you receive your prescription, and the amount we reimburse you may

be less than what you paid. You are responsible for this difference.

- You must file your claim to be reimbursed. See *Claims*, page 73.

Specialty Pharmacy Program

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

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

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

When you purchase covered drugs from nonparticipating pharmacies you are responsible for the amount charged for the drug at the time you fill your prescription, and then you must file a claim to be reimbursed. Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug, less your payment obligation. The maximum allowable fee may be less than the amount you paid. In other words, you are responsible for any difference in cost between what the pharmacy charges you for the drug and our reimbursement amount.

Mail Order Drug Program

When you fill your prescription through the mail order drug program, you will usually pay less than if you use a nonparticipating mail order pharmacy.

You must register as a mail service user in order to fill your prescriptions through the mail order drug program. For information on how to register, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Mail order pharmacy providers outside our mail order program are considered nonparticipating pharmacies. If you purchase covered drugs from nonparticipating mail order pharmacies, you will usually pay more.

When you purchase covered drugs from nonparticipating pharmacies you are responsible for the amount charged for the drug at the time you fill your prescription, and then you must file a claim to be reimbursed. Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug, less your payment obligation. The maximum allowable fee may be less than the amount you paid. In other words, you are responsible for any difference in cost between what the pharmacy charges you for the drug and our reimbursement amount.

See *Participating vs. Nonparticipating Pharmacies*, page 62.

6. Notification Requirements and Care Coordination

Iowa Choice

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

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

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

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

You or your authorized representative, if you have designated one, may appeal a denial of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 83. Also see *Authorized Representative*, page 91.

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 for Obtaining Precertification	**You** or someone acting on your behalf is responsible for obtaining precertification if: ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to precertification from a Participating Provider outside the Wellmark Blue HMO network. **Please note:** Services from Out-of-Network Providers or from Participating Providers must be approved through the Referral process described on page 43, except in the case of an emergency. Services from a Participating Provider may be covered if you are in the guest membership program. **Your Provider** should obtain precertification for you if: ■ You receive services subject to precertification from a Network Provider in Iowa; or ■ You receive inpatient services subject to precertification from a Participating Provider outside the Wellmark Blue HMO network. **Please note:** If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.
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.

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	Network Providers perform notification for you. However, you or someone acting on your behalf is responsible for notification if: ■ You receive services subject to notification from a provider outside the Wellmark Blue HMO network.

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

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 for Obtaining Prior Approval	**You** or someone acting on your behalf is responsible for obtaining prior approval if: ■ You receive services subject to prior approval from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to prior approval from a Participating Provider outside the Wellmark Blue HMO network. **Please note:** Services from Out-of-Network Providers or from Participating Providers must be approved through the Referral process described on page 43, except in the case of an emergency. Services from a Participating Provider may be covered if you are in the guest membership program. **Your Provider** should obtain prior approval for you if: ■ You receive services subject to prior approval from a Network Provider in Iowa; or ■ You receive inpatient services subject to prior approval from a Participating Provider outside the Wellmark Blue HMO network. **Please note:** If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.
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 benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. 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.

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

Prescription Drugs

Prior Authorization of Drugs

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

Process	Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription. Nonparticipating pharmacists will fill a prescription without prior authorization but you will be responsible for paying the charge. Wellmark will respond to a prior authorization request within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Calls received after 4:00 p.m. are considered the next business day.
Importance	If you purchase a drug that requires prior authorization but do not obtain prior authorization, you are responsible for paying the entire amount charged.

7. Factors Affecting What You Pay

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

Iowa Choice

Benefit Year

A benefit year is a period of 12 consecutive months beginning on January 1 or beginning on the day your coverage goes into effect. The benefit year 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 or you change to a different plan offering mid-benefit year from your same employer or group sponsor.

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

If you are an inpatient in a covered facility on the date of your annual benefit year renewal, your benefit limitations and payment obligations, including your deductible and out-of-pocket maximum, for facility services will 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.
- Benefits maximum.

How Coinsurance is Calculated

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

Wellmark Blue HMO and Out-of-Network Providers

You are eligible for benefits from Out-of-Network Providers only in cases of an emergency, accidental injury, or in certain situations, an approved referral.

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 39.

Out-of-Network Facility Services

For services received at Out-of-Network facilities, coinsurance is calculated using the amount charged after the following applicable amounts are subtracted from it:

- Deductible
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 39.

Participating Providers Outside the Wellmark Blue HMO Network

You are eligible for benefits from Participating Providers only in cases of an emergency, accidental injury, guest

membership, or in certain situations, an approved referral.

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 39.

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 payment arrangement amount for covered services after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 39.

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 44.

Provider Network

Under the medical benefits of this plan, your network of providers consists of Wellmark Blue HMO Providers. All other providers are not in your network.

Participating Providers

Participating Providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with the Wellmark Blue HMO network. When you receive services from Participating Providers:

- You are eligible for benefits only in limited situations. These are described in the *Choosing a Provider* section.
- Wellmark makes claim payments directly to these providers.

Network Providers

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

- The Network payment obligation amounts may be waived for certain covered services. See *Waived Payment Obligations*, page 8.

There may be certain exceptions. Any exceptions are described in *What You Pay*.

Out-of-Network Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with Out-of-Network Providers, and they may not accept our payment arrangements. Pharmacies other than those participating in the specialty pharmacy program that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. Therefore, when you receive services from Out-of-Network Providers:

- You are not eligible for benefits. There may be exceptions to this rule for specific services. If so, these are described in the section *Details – Services Covered and Not Covered*.
- 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.
- Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.
- The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you. 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 Network Providers. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

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

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a Participating or Network provider. For the majority of services, the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or Network 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 an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 39.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a

provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:

- Deductible.
- Coinsurance.
- Copayment.
- Amounts representing any general exclusions and conditions.
- Network savings.

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

Provider Payment Arrangements
Provider payment arrangements are calculated using industry methods including, but not limited to, fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. Wellmark Blue HMO and Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

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

Pharmacy Benefits Manager Fees and Drug Company Rebates

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

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

Prescription Drugs

Benefit Year

A benefit year is a period of 12 consecutive months beginning on January 1 or beginning on the day your coverage goes into effect. The benefit year 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 or you change to a different plan offering mid-benefit year from your same employer or group sponsor.

Certain coverage changes result in your Wellmark identification number changing. In some cases, a new benefit year will start under the new ID number for the rest of the benefit year. In this case, the benefit year would be less than a full 12 months. In other cases (e.g., adding your spouse to your

coverage) the benefit year would continue and not start over.

The benefit year is important for calculating:

- Out-of-pocket maximum.

Wellmark Blue Rx Complete Drug List

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

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

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

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

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

If a drug is not on the Wellmark Blue Rx Complete Drug List and you believe it should be covered, refer to *Exception Requests for Non-Formulary Prescription Drugs,* page 75.

The Wellmark Blue Rx Complete Drug List is subject to change.

Tiers

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

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

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

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

Tier 4. Drugs available as combination products or lifestyle drugs. Tier 4 drugs have the same payment obligation as Tier 3 drugs.

Generic and Brand Name Drugs

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

Generic Drug

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

Brand Name Drug

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

What You Pay

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

Quantity Limitations

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

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

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

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

Amount Charged and Maximum Allowable Fee

Amount Charged

The retail price charged by a pharmacy for a covered prescription drug.

Maximum Allowable Fee

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

The maximum allowable fee may be less than the amount charged for the drug.

Participating vs. Nonparticipating Pharmacies

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

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

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

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

Preferred vs. Non-Preferred Specialty Drugs

The amount you pay for specialty drugs covered under your Blue Rx Complete prescription drug benefits depends on whether the specialty drug is categorized as preferred or non-preferred.

Preferred Specialty Drugs have been proven to be safe, effective, and favorably priced compared to non-preferred alternatives that treat the same condition. Drugs may also be classified as preferred because no alternative drug exists.

Non-Preferred Specialty Drugs are drugs without sufficiently documented clinical evidence that they provide a

significant benefit over available preferred alternatives.

To determine whether a specialty drug is preferred or non-preferred, consult the Wellmark Blue Rx Complete Drug List at *Wellmark.com*. Also see *Specialty Drugs*, page 29.

Special Programs

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

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

Savings and Rebates

Payment Arrangements

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

Pharmacy Benefits Manager Fees and Drug Company Rebates

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

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

8. Coverage Eligibility and Effective Date

Eligible Members

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

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

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

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 deemed disabled. The disability must have existed before the child turned age 26 or while the child was a full-time student. Wellmark considers a dependent disabled when he or she meets the following criteria:
  - Claimed as a dependent on the employee's, plan member's, subscriber's, policyholder's, or retiree's tax return; and
  - Enrolled in and receiving Medicare benefits due to disability; or
  - Enrolled in and receiving Social Security benefits due to disability.

  Documentation will be required.

When Plan Member and Spouse Are Both Eligible Employees

When a husband and wife are both employed by the State, they may enroll in single or family coverage. Employees cannot be covered as both an employee and a spouse 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 69.

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*.

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 69.

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

If you are subject to a waiting period that expires more than 90 days after we receive the QMCSO, your 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 the cost of coverage 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 (https://das.iowa.gov/*human*-resources/employee-and-retiree-*benefits*) 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. In the event of a birth, notification to your employer or group sponsor is required for both single and family policyholders. Notification must occur within 60 days of 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. The single contract holder will not be able to change benefits until the next annual enrollment and change period unless another qualified life event occurs during the year and the benefit change requested is consistent with the qualifying event.

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 decide to discontinue offering this group health benefit plan by giving written notice to you and your employer or group sponsor and the Commissioner of Insurance at least 90 days prior to termination.
- We decide to nonrenew all group health benefit plans delivered or issued for delivery to employers in Iowa by giving written notice to you and your employer or group sponsor and the Commissioner of Insurance at least 180 days prior to termination.
- The number of individuals covered under this group health plan falls below the number or percentage of eligible individuals required to be covered.
- Your employer sends a written request to terminate coverage.

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

When you become unemployed and your eligibility is based on employment, your coverage will end at the end of the month your employment ends. When your coverage terminates for all other reasons, check with your 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

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

Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this group health plan.

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.

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

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

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

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

notify Wellmark of the continuation or reenrollment request.

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

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

10. Claims

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

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

When to File a Claim

You need to file a claim if you:

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

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

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

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

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

2. Fill Out the Claim Form

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

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

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

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

- For injury or illness: date and diagnosis.
- For inpatient claims: admission date, patient status, attending physician ID.
- Days or units of service.
- Revenue, diagnosis, and procedure codes.
- Description of each service.

Prescription Drugs Covered Under Your Medical Benefits Claim Form. For prescription drugs covered under your medical benefits (not covered under your Blue Rx Complete prescription drug benefits), use a separate prescription drug claim form and include the following information:

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

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

- Use a separate claim form for each covered family member and each pharmacy.
- Complete all sections of the claim form. Include your daytime telephone number.
- Submit up to three prescriptions for the same family member and the same pharmacy on a single claim form. Use additional claim forms for claims that exceed three prescriptions or if the prescriptions are for more than one family member or pharmacy.
- Attach receipts to the back of the claim form in the space provided.

3. Sign the Claim Form

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

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

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

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

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

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

Notification of Decision

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

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

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

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 77.

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

Exception Requests for Non-Formulary Prescription Drugs

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

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

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

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

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that are not on the Wellmark Blue Rx Complete Drug List. It is not available for items that are specifically excluded under your benefits, such as cosmetic drugs, convenience packaging, non-FDA approved drugs, infused drugs, most over-the-counter medications, nutritional, vitamin and dietary supplements, or antigen therapy. The preceding list of excluded items is illustrative only and is not a complete list of items that are not eligible for the process.

Request for Benefit Exception Review

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

Services subject to this exception process:

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

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

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

11. Coordination of Benefits

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

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

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

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

Other Coverage

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

- Group and nongroup insurance contracts and subscriber contracts.
- HMO contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term contracts, such as skilled nursing care.
- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

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

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

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

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

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.

*If you purchase a brand name drug that has an FDA-approved “A”-rated generic equivalent, Wellmark will pay only what it would have paid for the equivalent generic drug. In this case, in addition to your copayment or coinsurance, you will also be responsible for any cost difference between the generic drug and the brand name drug, up to the maximum allowed fee for the brand name drug.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services or obtain a covered prescription drug, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier’s explanation of benefit payment within 180 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

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

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

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

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (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.
- Notwithstanding the preceding rules, when you present your Blue Rx Complete ID card to a pharmacy as the primary payer, your Blue Rx Complete prescription drug benefits are primary for prescription drugs purchased at the pharmacy. If, under the preceding rules, your Blue Rx Complete prescription drug benefits are secondary and you present your Blue Rx Complete ID card to a pharmacy as the secondary payer, your Blue Rx Complete prescription drug benefits are secondary for prescription drugs purchased at the pharmacy.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Dependent Children

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

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

health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

— If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

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

Coordination with Noncomplying Plans

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

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited to the amount we would have paid had this plan been primary.
- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 94.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the

claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

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

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

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

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

Coordination with Medicare

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

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

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.

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

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 eligibility if both of the following are true:

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

This is only a general summary of the laws. For complete information, contact your 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 91.

Medically Urgent Appeal

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

Non-Medically Urgent Appeal

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

What to Include in Your Internal Appeal

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

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

For a prescription drug appeal, you also must submit:

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

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

Where to Send Internal Appeal

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

Review of Internal Appeal

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

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

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

Decision on Internal Appeal

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

Medically Urgent Appeal

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

All Other Appeals

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

External Review

You have the right to request an external review of a final adverse determination involving a covered service when the determination involved:

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 51.
- A rescission of coverage.

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

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

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

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

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

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

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

Iowa Insurance Division
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 investigational or experimental and your treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, you may also have the right to request an expedited external review.

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

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

Arbitration and Legal Action

You shall not start arbitration or legal action against us until you have exhausted the appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 93, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

13. Arbitration and Legal Action

PLEASE READ THIS SECTION CAREFULLY

Mandatory Arbitration

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

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

Covered Claims

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

Except as stated below, all Claims are subject to mandatory arbitration, no matter what legal theory they are based, whether in law or equity, upon or what remedy (damages, or injunctive or declaratory relief) they seek, including Claims based on contract, tort (including intentional tort), fraud, agency, your or our negligence, statutory or regulatory provisions, or any other sources of law; counterclaims, cross-claims, third-party claims, interpleaders or otherwise; Claims made regarding past, present or future conduct; and Claims made independently or with other claims. This also includes Claims made by or against anyone connected with us or you or claiming through us or you, or by someone making a claim through us or you, such as a covered family member, employee, agent, representative, or an affiliated or subsidiary company. For purposes of this *Arbitration and Legal Action* section, the words "we," "us," and "our" refer to Wellmark, Inc. and its subsidiaries and affiliates, the plan sponsor and/or the plan administrator, as well as their respective directors, officers, employees and agents.

No Class Arbitrations and Class Actions Waiver

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

Claims Excluded from Mandatory Arbitration

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

AN ARBITRATOR DETERMINES A PARTICULAR CLAIM IS EXCLUDED FROM ARBITRATION BY FEDERAL OR STATE LAW, CLAIMS EXCLUDED BY APPLICABLE LAW, LATER IN THIS SECTION, AND GOVERNING LAW, PAGE 93, WILL APPLY TO THE PARTIES AND SUCH PARTICULAR CLAIM.

Arbitration Process Generally

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

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

Arbitration Fees and Other Costs

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

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

Confidentiality

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

Questions of Arbitrability

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

Claims Excluded By Applicable Law

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

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

Survival and Severability of Terms

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

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

14. General Provisions

Contract

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

- Any application you submitted to us or to your 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, subject to the appeal procedures outlined earlier in this benefit booklet.

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.

Plan Year

The Plan Year has been designated and communicated to Wellmark by your group health plan’s plan sponsor or plan administrator as the twelve month period commencing on the effective date of your group health plan's annual renewal with Wellmark.

Authority to Terminate, Amend, or Modify

Your 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 69.

Member Participation

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

Authorized Representative

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

at *Wellmark.com* or by calling the Customer Service number on your ID card.

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

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

Release of Information

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

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

Privacy of Information

Your 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. If you give us an authorization,

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

Member Health Support Services

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

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

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

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include Blue365®, identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Value-Based Programs

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

Nonassignment

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

Governing Law

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

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

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

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

Enrollment Without Regard to Medicaid

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

Acquisition by States of Rights of Third Parties

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

Medicaid Reimbursement

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

Subrogation

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

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

Right of Subrogation

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

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

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

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

Procedures for Subrogation and Reimbursement

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

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by us.

Send this information to:

Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue, Station 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 group health plan for an injury or condition that is the subject or basis of a workers' compensation claim (whether litigated or not), we are entitled to reimbursement to the extent benefits are paid under this plan in the event that your claim is accepted or adjudged to be covered under workers' compensation.

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

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

Payment in Error

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

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

Notice

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

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

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

Inspection of Coverage

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

Submitting a Complaint

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

Consent to Telephone Calls and Text or Email Notifications

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

Glossary

The definitions in this section are terms that are used in various sections of this 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 or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

BlueCard Program. The Blue Cross Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to emergency care or accidental injury services similar to those that members have in the Wellmark Blue HMO network.

Compounded Drugs. Compounded prescription drugs are produced by combining, mixing, or altering ingredients by a pharmacist to create an alternate strength or dosage form tailored to the specialized medical needs of an individual patient when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs.

Creditable Coverage. Any of the following categories of coverage:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

Domestic Partner. An unmarried person who has signed the Certification of Domestic Partnership form with the plan member.

Extended Home Skilled Nursing. Home skilled nursing care, other than short-term home skilled nursing, provided in the home by a registered (R.N.) or licensed practical nurse (L.P.N.) who is associated with an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency that is ordered by a physician and consists of four or more hours per day of continuous nursing care

that requires the technical proficiency and knowledge of an R.N. or L.P.N.

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

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

Illness or Injury. Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

Inpatient. Services received, or a person receiving services, while admitted to a health care facility for at least an overnight stay.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

Medically Urgent 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 Pharmacy. A pharmacy that does not participate with the network used by your prescription drug benefits.

Office. An office setting is the room or rooms in which the practitioner or staff provide patient care.

Out-of-Network Provider. A facility or practitioner that does not participate with either the Wellmark Blue HMO network or a Blue Cross or Blue Shield Plan in any other state. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

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

Participating Pharmacy. A pharmacy that participates with the network used by your prescription drug benefits. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area but not with the Wellmark Blue HMO network.

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

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

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.

Specialty Drugs. Drugs that are typically used for treating or managing chronic illnesses. These drugs are subject to restricted distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or patient education that may not be provided by a retail pharmacy. Some specialty drugs may

be taken orally, but others may require administration by injection or inhalation.

Spouse. A man or woman lawfully married to a covered member.

Urgent Care Centers are classified by us as such in Iowa if they provide medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room. For a list of Iowa facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.

We, Our, Us. Wellmark Health Plan of Iowa, Inc.

Wellmark Blue HMO Provider. A facility or practitioner that participates with Wellmark Health Plan of Iowa, Inc.

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

You, Your. The plan member and family members eligible for coverage under this group health plan.

Index

A

abuse of drugs 35
accident deductible 6
accidental injury 20
acupressure 17
acupuncture 13, 17
addiction 13, 18
administrative services 14, 27, 41
admissions 51, 52
adoption 65
advanced registered nurse practitioners 15, 29
allergy services 13, 17
ambulance services 13, 17
ambulatory facility 24
ambulatory facility services 20
amount charged 59, 62
anesthesia 13, 18, 20
antigen therapy 30, 35
appeals 51, 83
arbitration 87, 88, 89
arbitration fees 89
assignment of benefits 93, 94
audiologists 15, 29
authority to terminate or amend 91
authorized representative 91
autism 13, 18

B

benefit coordination 77
benefit year 57, 60
benefit year deductible 5
benefits maximums 8, 13
bereavement counseling 20
biological products 29
blood 13, 18
BlueCard program 44, 57
bone marrow transplants 33
braces 23, 26, 31
brain injuries 55
brand name drugs 61
breast reconstruction 32

C

capitation 60
care coordination 51
case management 55
changes of coverage 69
chemical dependency 13, 18
chemical dependency treatment facility 24
chemotherapy 13, 19
child support order 66
children 65, 66, 79
chiropractic services 14, 27
chiropractors 15, 29
claim filing 73, 78
claim forms 73
claim payment 74
claims 73
claims excluded by applicable law 89
class actions waiver 87
clinical trials 13, 19
COBRA coverage 71
coinsurance 4, 7, 57
common accident deductible 6
communication disorders 27
community mental health center 24
complaints 97
complications 41
compounded drugs 35
concurrent review 54
conditions of coverage 39
confidentiality 89
contact lenses 33
contraceptive devices 36
contraceptives 13, 19, 20
contract 91
contract amendment 91
contract interpretation 91, 93
convenience items 14, 25
convenience packaging 36
conversion therapy 13, 20

coordination of benefits 77
coordination of care....51
copayment 5, 6, 10
cosmetic drugs 36
cosmetic services 13, 20
cosmetic surgery 15, 32
counseling 14, 20
coverage changes 69, 91
coverage continuation 71
coverage effective date.... 66
coverage eligibility 65
coverage termination.... 70
covered claims.... 87
custodial care 23
cystic fibrosis.... 55

D

damaged drugs.... 36
deductible.... 5
deductible amounts 4
degenerative muscle disorders.... 55
dental services.... 14, 20
dependents....65, 66, 79
DESI drugs 29
diabetes 14, 21
diabetic education....14, 21
diabetic supplies 26
dialysis....14, 21
dietary products.... 14, 27, 28, 36
disabled dependents 65
doctors....15, 29
doctors of osteopathy 15, 29
domestic partners 65
drug abuse....13, 18, 35
drug prior authorization.... 55
drug quantities....36, 62
drug rebates 60, 63
drug refills 36
drug tiers 61, 62
drugs....15, 29, 34, 61
drugs that are not FDA-approved....30, 35

E

education.... 14, 20
effective date 66
eligibility for coverage....65
emergency room copayment 4, 6
emergency services.... 14, 21, 47
employment physicals.... 31
EOB (explanation of benefits) 74
exclusions 39, 40
expedited external review....85
experimental services.... 40
explanation of benefits (EOB) 74
eye services 15, 33
eyeglasses....33

F

facilities....14, 24
family counseling 20
family deductible....5
family member as provider.... 41
FDA-approved A-rated generic drug 61
fertility services 14, 22
filing claims 73, 78
foot care (routine) 25
foot doctors....15, 29
foreign countries 36, 46
foster children 65
fraud....70

G

gamete intrafallopian transfer....22
generic drugs 61
genetic testing....14, 22
GIFT (gamete intrafallopian transfer) 22
government programs.... 41, 77
guest membership 48
gynecological examinations....15, 30

H

hairpieces.... 15, 33
hearing services....14, 22
hemophilia....55
high risk pregnancy....55
home health services....14, 22
home infusion therapy....29
home office (Wellmark) 97
home/durable medical equipment....14, 23
hospice respite care....24
hospice services 14, 24

hospital services....20, 70
hospitals 14, 24

I

ID card....43, 44, 49
illness.... 14, 24
impacted teeth 20
in vitro fertilization.... 22
infertility drugs 36
infertility treatment 14, 22
information disclosure 92
infused drugs 36
inhalation therapy 14, 23, 25
injury 14, 24
inpatient facility admission....51, 52
inpatient services 57, 70
inspection of coverage 97
insulin....30
investigational or experimental drugs.... 35
investigational services 40
irrigation solutions and supplies 36

K

kidney dialysis....21

L

L.P.N.... 22
laboratory services....15, 34
late enrollees 66
licensed independent social workers....15, 29
licensed practical nurses 22
lifetime benefits maximum 42
limitations of coverage 8, 13, 39, 42, 62
lodging....15, 33
long term acute care facility 24
long term acute care services 25
lost or stolen items 36

M

mail order drug program.... 50
mail order drugs 50
mammogram (3D)....30
mammograms.... 15, 30
marriage counseling 20
massage therapy 27
mastectomy.... 32
maternity services 14, 25
maximum allowable fee 59, 62
medicaid enrollment 94
medicaid reimbursement....94
medical doctors 15, 29
medical equipment....14, 23, 36
medical supplies 14, 25
medical support order....66
medically necessary....39
Medicare 77
medication therapy management 30, 36
medicines.... 15, 29, 34, 61
mental health services....14, 26
mental health treatment facility....24
mental illness....14, 26
military service 41
misrepresentation of material facts 70
morbid obesity treatment 14, 27
motor vehicles 14, 27
muscle disorders 55
musculoskeletal treatment 14, 27

N

network providers 43, 58
network savings....59
nicotine dependence 30, 31
nicotine dependency drugs....35
nonassignment of benefits....93
nonmedical services 14, 27, 41
nonparticipating pharmacies 49, 62
notice....97
notification of change 69
notification requirements 51
nursing facilities 24, 70
nutrition education 14, 21
nutritional products 14, 27, 28

O

obesity treatment 14, 27
occupational therapists....15, 29
occupational therapy....14, 23, 28
office visit copayment 4, 6
optometrists....15, 29
oral contraceptives 20
oral surgeons 15, 29

organ transplants....15, 33
orthotics 14, 28
osteopathic doctors....15, 29
other insurance....41, 77
out-of-area coverage.... 36, 44, 57
out-of-network providers.... 59
out-of-pocket maximum 4, 5, 7, 10
oxygen 23, 26

P

packaging 36
Pap smears 15, 30
participating pharmacies 49, 62
participating providers....43, 58
payment arrangements 59, 63
payment in error.... 96
payment obligations 4, 8, 11, 39, 42, 49, 57, 61, 62
personal items....14, 25
physical examinations 15, 30
physical therapists....15, 29
physical therapy.... 15, 23, 28
physician assistants....15, 29
physicians....15, 29
plan year....91
plastic surgery.... 13, 20
podiatrists 15, 29
practitioners....15, 29
precertification....42, 51
pregnancy.... 24, 25
pregnancy (high risk) 55
prenatal services 25
prescription drugs 15, 29, 34, 61
preventive care.... 15, 30
preventive items 35
preventive services.... 35
prior approval 42, 53
prior authorization 42, 55
privacy.... 92
pronuclear stage transfer (PROST) 22
prosthetic devices 15, 23, 31
provider network 3, 43, 58
psychiatric medical institution for children (PMIC).... 24
psychiatric services.... 26
psychologists 15, 29
public employees.... 71
pulmonary therapy....14, 23, 25

Q

qualified medical child support order....66
quantity limits 36, 62

R

R.N. 15, 22, 25, 29
radiation therapy.... 13, 19
rebates.... 60, 63
reconstructive surgery 15, 32
referrals....43
refills 36
registered nurses 15, 22, 25, 29
reimbursement of benefits.... 94, 96
release of information....92
respiratory therapy....14, 23, 25
rights of appeal....83
routine services 15, 30

S

self-help 15, 32
service area 44
short-term home skilled nursing....22
skilled nursing services....22
sleep apnea 15, 32
social adjustment 15, 32
social workers 15, 29
specialty drugs....29
specialty pharmacy program 50
speech pathologists 15, 29
speech therapy....15, 32
spinal cord injuries....55
sports physicals 31
spouses....65
stepchildren....65
sterilization....22
students 65
subrogation....94
surgery 15, 32
surgical facility 24
surgical facility services 20
surgical supplies 14, 25
survival and severability of terms 89

T

take-home drugs 30, 34
telehealth 15, 32
telehealth services copayment 4, 6
temporomandibular joint disorder 15, 33
termination of coverage 70
therapeutic devices 36
third party liability 41
TMD (temporomandibular joint disorder) . 15, 33
tooth removal 20
transplants 15, 33, 55
travel 15, 33
travel physicals 31
tubal ligation 22

U

urgent care center copayment 4, 7

V

vaccines 29
vasectomy 22
vehicles 14, 27
vision services 15, 33

W

weight reduction 14, 27
weight reduction drugs 36
well-child care 15, 30
Wellmark drug list 61
wigs 15, 33
workers' compensation 41, 96

X

x-rays 15, 34

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