Wellmark Health Plan of Iowa

WellmarkBlue HMO℠

Health Plans

FOR INDIVIDUALS AND FAMILIES

PLAN OPTIONS: SimplyBlue℠, CompleteBlue℠, CompleteBlueMax℠, EnhancedBlueMax℠, and myBlue HSA℠

OUTLINE OF COVERAGE
for ACA Plans

M-93110 07/15

You should read your policy carefully. This Outline of Coverage for WellmarkBlue HMO plans provides a brief description of the important features of your policy. This is not your policy. Only the actual benefit provisions in your policy will determine your benefits. The policy itself sets forth in detail the rights and obligations of both you and Wellmark Health Plan of Iowa, Inc. (Wellmark Health Plan).

THEREFORE, IT IS IMPORTANT THAT YOU READ YOUR POLICY CAREFULLY.

If you have questions about WellmarkBlue HMO plans but have not submitted an application, please contact Wellmark's Customer Service at **800-978-3221.** If you are a current Wellmark member, please call the number located on the back of your ID card.

Premium payments[1] may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example:

Payment Frequency	Description
Monthly	Premium payment would be for the first day of the month through the last day of such month through electronic funds transfer (EFT) only.
Quarterly	Premium payment is made through electronic funds transfer (EFT) only. Standard quarterly periods are: • January 1 through March 31 • April 1 through June 30 • July 1 through September 30 • October 1 through December 31
Semi-Annual	Premium payment would be for the calendar period of either: • January 1 through June 30, or • July 1 through December 31
Annual	Premium payment would be for January 1 through December 31 of the applicable year.

In any year in which there is a mid-year adjustment in the amount of premium(s), the member will have the following obligation:

Payment Frequency	Obligation
Monthly	Monthly payments will continue to be made through electronic funds transfer (EFT) only. For monthly premium payments, any increase will be deducted from the member's designated account in the first month the increase becomes effective. For each month thereafter, the increased monthly premium will automatically be deducted.
Quarterly	Quarterly payments will continue to be made through electronic funds transfer (EFT) only. For quarterly premium payments, any increase for the remaining portion of a quarter will be deducted from the member's designated account in the month the increase becomes effective. For each quarter thereafter, the increased monthly premium will automatically be deducted.
Semi-Annual	For semi-annual payments, the member must pay a bill for a premium payment representing the difference between the new semi-annual premium amount and the amount previously paid for such period. The member also will be required to pay subsequent semi-annual premiums that include the premium increase.
Annual	For an annual premium payment, the member must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

The amount of your periodic premium payment will change as provided in the policy and from time to time based on changes in your coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco use status, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy renewal.

If you elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. Your authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless you call or provide your bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If you call your bank to stop payment, you may be required to provide a written request within fourteen (14) days after your call. You will be responsible for any fee assessed by your bank for stop-payment orders that you make.

[1] *A component of your premium are the federal fees and taxes as required by the Affordable Care Act (ACA). Transitional Reinsurance Fee is to help stabilize the cost of premiums in the individual market during the first three years the Health Insurance Marketplace is in effect. Annual Heath Insurer Fee is to help fund reforms made according to the ACA. These fees are a percentage of your premium and are required to be paid by all members.*

WellmarkBlue HMO℠ Plans

CHOOSING A PROVIDER

This medical benefits plan is called WellmarkBlue HMO. Providers who participate with this plan are called Wellmark Health Plan Network providers. You can feel secure knowing that 96 percent of physicians and 100 percent of hospitals in Iowa participate in the Wellmark Health Plan Network. **Generally, there are no benefits for services received outside of the Wellmark Health Plan Network, except for emergencies or accidental injuries.**

Providers who do not participate with this plan are called out-of-network, nonparticipating providers. With WellmarkBlue HMO, it is usually to your advantage to visit your designated primary care provider (personal doctor) for most covered services. If your designated personal doctor is unable to diagnose or treat your condition, he or she may refer you to another Wellmark Health Plan Network provider. Generally, benefits are available only when received from designated personal doctor or Wellmark Health Plan Network providers. To determine if a provider participates with this medical benefits plan, ask your provider, visit our website at Wellmark.com, refer to your provider directory (a separate document that's available, without charge), or call Wellmark Customer Service.

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

Designated personal doctor

Your designated primary care provider (personal doctor) evaluates your medical condition and either treats your condition or coordinates services you require. You must choose a personal doctor from the Wellmark Health Plan Network. You have the right to choose any personal doctor who participates in the Wellmark Health Plan Network and who is available to accept you or your family members.

All family members must select a designated personal doctor for claims to be paid, including family members who live outside the Wellmark Health Plan Network area (limited to college students under guest membership). Each member may choose his or her own primary care provider. For a covered child, you may choose a pediatrician as the designated personal doctor. Female members may receive gynecological and maternity services from their designated personal doctor or choose an obstetrical/ gynecological (OB/GYN) care provider from the Wellmark Health Plan Network.

When you need medical care, you can expect it in a timely manner. The following are Wellmark Health Plan reasonable expectations for timely, appropriate care. Expect your personal doctor to schedule appointments for you according to the following standards:

- Routine physicals within eight weeks,
- Non-urgent routine care (with no symptoms) within four weeks,
- Non-urgent routine care with symptoms within seven calendar days,
- Urgent, acute care within 24 hours,
- Emergency care assessment, treatment, or referral — immediately,
- All personal doctors will provide or arrange for covered services for you 24 hours a day, seven days a week, including holidays.

For information on the nearest after-hours care facility, please consult your online provider directory or call the number located on the back of your ID card.

If your designated personal doctor is not available, he or she will designate a backup provider. If your designated personal doctor leaves the Wellmark Health Plan Network, you will be notified and required to choose another personal doctor. For information on how to select a personal doctor or for a list of participating personal doctors, call Wellmark Customer Service or visit our website, Wellmark.com.

When you need emergency treatment, you should try to contact your designated personal doctor first, for direction and guidance. If this is not possible, and you believe this situation is serious, do not wait. Dial 911 or go to the nearest emergency facility immediately to get the care you need.

Note: Contact your provider's office for information on board certification status, medical school attended, and completion of residency.

Changing your designated personal doctor

If you or a family member decides to switch to a different personal doctor or OB/GYN, submit a change form, or call Wellmark Customer Service. Changes will be in effect by the first day of the month following receipt of your request.

Referrals

If you require services from a provider other than your designated personal doctor, typically a specialist, you will be referred to a provider in the Wellmark Health Plan Network. If you require services that are not available from a specialist within the Wellmark Health Plan Network, you will be referred to a provider outside the Wellmark Health Plan Network who has expertise in diagnosing and treating your condition. Wellmark Health Plan must approve out-of-network referrals before you receive services or the services will not be covered.

Note: Even when your out-of-network referral is approved, you are still responsible for complying with notification requirements.

Primary care providers (PCP)

Primary Care Providers are a type of provider you go to for your primary care, other than your designated personal doctor. PCPs include family practitioners, internal medicine practitioners, obstetricians/gynecologists, pediatricians, physicians assistants and advanced registered nurse practitioners.

Balance billing

This is the difference between a non-Wellmark Health Plan provider's billed charge and what Wellmark will pay for a specific service, procedure, or supply. When you receive emergency care, and, in some cases, non-emergency services from a provider who is not part of the network, you are responsible for paying this difference. You are also responsible for paying this difference even with a referral for a non-emergency service if the provider is not part of the network. To avoid being balance-billed, select a health care provider who participates in the "traditional" BlueCard® network. Non-emergency care is not covered for non-network providers. Balance billed amounts do not apply toward your deductible or out-of-pocket maximum and are not used to calculate your coinsurance percentage.

Preventive care

Generally, when you receive your annual physical exam, or your annual gynecological exam, you must receive the exam from your designated personal doctor or your selected OB/GYN to receive benefits.

This product is not available for sale in the following counties: Allamakee, Fayette, Winneshiek

About **WellmarkBlue** HMO℠

THE WELLMARK BLUE HMO® PLANS outlined here and detailed in the policies are Health Maintenance Organization (HMO) health plans designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care. Covered services are subject to deductible, coinsurance and copayment provisions, or other limitations set forth in the policy.

This coverage is available to you ("single" coverage) or to you and your family ("family" coverage), including your spouse and/or eligible dependent children; or to your dependents only ("child-only" coverage). A child-only policy is a single policy in which the primary applicant is age 20 or younger, or a policy of multiple siblings in which the primary applicant is the youngest child and is age 20 or younger. You will pay the premium required for coverage directly to Wellmark Health Plan.

For language assistance, call the Customer Service number located on the back of your ID card. Para asistencia en idiomas, llame a Servicio de Atencion al Cliente.

Office services received from a Wellmark Health Plan Network provider

Covered office services include office visits and consultations, X-rays, laboratory testing, and minor surgery, and most outpatient X-rays and laboratory testing billed by a Wellmark Health Plan Network facility when your Wellmark Health Plan Network provider refers you to the facility.

SimplyBlue℠

Under our *SimplyBlue* plans, you are not required to pay any deductible amount for covered office services performed by a Wellmark Health Plan Network primary care physician.

Note for SimplyBlue℠ plans: The deductible is not waived for CT scans, MEGs, MRAs, MRIs, PET scans, radiation therapy, ultrasound, office labs and X-rays, and independent labs.

CompleteBlue℠

Under our *CompleteBlue* plan, you are not required to pay any deductible amount for covered office services performed by a Wellmark Health Plan Network provider.

myBlue HSA℠

Under our *myBlue HSA* health plan, you are required to pay the deductible amount for covered office services performed by a Wellmark Health Plan Network provider.

CompleteBlue Max℠

Under our *CompleteBlue Max* plan, you are not required to pay any deductible when using a Wellmark Health Plan Network provider.

EnhancedBlue Max℠

Under our *EnhancedBlue Max* plan, you are not required to pay any deductible when using a Wellmark Health Plan Network provider.

Note for CompleteBlue℠, myBlue HSA℠, CompleteBlue Max℠, and EnhancedBlue Max℠ plans: The deductible is not waived for CT scans, MEGs, MRAs, MRIs, PET scans, radiation therapy and ultrasound.

Services outside the Wellmark Health Plan Network

Generally, there are no benefits for medical services received outside of the Wellmark Health Plan Network, except in the following situations:

- Accidental Injuries
- Emergencies

BlueCard Program

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 and Blue Shield Association. We have relationships with other Blue Cross and/or Blue Shield Plans. These relationships are generally referred to as Inter-Plan Programs. Whenever you obtain services outside the Wellmark Health Plan Network, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program. These programs ensure that members of any Blue Plan have access to the advantages of participating providers throughout the United States. Participating providers have a contractual 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 Health Plan Network area for emergency care or accidental injury similar to those you would have in the Wellmark Health Plan 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 Health Plan 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 BlueCard providers in any state, call **800-810-BLUE**, or visit Bcbs.com.

When you receive covered services from BlueCard providers outside the Wellmark Health Plan 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 health plan payment is sent directly to the providers.
- You are responsible for notification requirements.

Out-of-network/nonparticipating providers

When you receive covered services for accidental injuries, emergencies, or guest membership from out-of-network, nonparticipating providers, all of the following statements are true:

- Out-of-network, nonparticipating providers are not responsible for filing your claims. If you need a claim form or have questions on how to submit a claim, please call the Customer Service phone number located on your ID card.
- We do not have contracts with out-of-network, nonparticipating 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, nonparticipating providers.
- You are responsible for notification requirements.

Eligibility for Wellmark Health Plan coverage

All persons seeking coverage with Wellmark Health Plan must be residents of Iowa and live in the Wellmark Health Plan service area. If coverage is issued, all covered persons must continue to live in the Wellmark Health Plan service area because there are generally no benefits for medical services outside the Wellmark Health Plan Network except for emergency or accidental injuries.

Guest membership

Covered dependents attending college out of state are eligible to become a guest member any time they are outside the Wellmark Health Plan Network area for at least 90 days. Not all services covered under the medical benefits plan are covered under Guest Membership. To determine which services are covered under the Guest Membership program, call us.

To set up a guest membership, follow the guidelines listed below:

- Before a covered dependent leaves the Wellmark Health Plan Network area to attend college, he or she should call the Customer Service number on his or her ID card.

This plan does not include coverage for pediatric dental services

This health plan does not include pediatric dental services as described under the Federal Patient Protection and Affordable Care Act. Pediatric dental coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, producer, or Iowa's Partnership Marketplace Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Benefits

Approved hospital/health care facility services

WellmarkBlue HMO health plans provide medically necessary services and supplies related to the treatment of an illness or injury as an inpatient in a facility.

Approved health care facilities include ambulatory surgical facilities, hospitals, and nursing facilities. All WellmarkBlue HMO plans also consider community mental health centers and facilities for treatment of chemical dependency to be approved health care facilities.

Note: Even though a facility may participate in the Wellmark Health Plan Network, other providers within the facility, such as emergency room providers, anesthetists, home medical equipment suppliers, and others may not participate with the Wellmark Health Plan Network. It is important to ask if the provider participates in the Wellmark Health Plan Network before you receive covered services.

Inpatient services

All WellmarkBlue HMO plans cover:

- Accidental injury care
- Anesthetics and their administration
- Blood administration
- Chemotherapy services
- Maternity
- Dialysis services
- Drugs and biologicals
- Education services for diabetes
- Emergency care
- General nursing care
- Inhalation therapy
- Intravenous administration
- Medical and surgical supplies such as dressing and casts
- Mental health and chemical dependency treatment
- Occupational therapy to treat the upper extremities — see *Limitations* section.
- Physical therapy — see *Limitations* section
- Speech therapy treatment — see *Limitations* section

Outpatient services

All WellmarkBlue HMO plans cover:

- Accidental injury care
- Anesthetics and their administration
- Chemotherapy services
- Dialysis services
- Drugs and biologicals
- Education services for diabetes
- Emergency care
- Inhalation therapy
- Intravenous administration
- Medical and surgical supplies such as dressing and casts
- Mental health and chemical dependency treatment
- Occupational therapy to treat the upper extremities
- Physical therapy
- Rehabilitative speech therapy treatment
- Musculoskeletal services (Spinal manipulations are limited to a total of 12 self-referred visits per member per benefit period)

Approved provider services

The following list describes approved provider services for all WellmarkBlue HMO plans:

- Accidental injury services
- Allergy testing and treatment
- Anesthetics and their administration
- Certain dental services
- Chemotherapy
- Maternity
- Concurrent care
- Dialysis services
- Emergency care
- Genetic testing and related counseling in certain circumstances
- Medical services-other than surgical or obstetrical
- Musculoskeletal services (spinal manipulations are limited to a total of 12 self-referred visits per member per benefit period)
- Occupational therapy to treat the upper extremities
- Physical therapy
- Preventive care, including:
  - Implanted and injected contraceptives and contraceptive medical devices — oral contraceptives are covered under your drug policy
  - Immunizations
  - One routine gynecological exam per member per benefit period.
  - One routine mammogram per member per benefit period.
  - One routine physical examination and related services per member per benefit period.
  - Routine pap smears.

  - Well-child care including age appropriate pediatric preventive services until the child reaches the age of 7
- Radiation therapy
- Rehabilitative speech therapy treatment
- Surgical services
- Reconstructive surgery
- Fertility and infertility services
  - Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only)
  - Fertility and infertility services until you receive artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure
- X-ray and laboratory services
- Pediatric vision — vision services for members under age 19 (one routine vision examination per benefit year)

Organ transplant coverage

Coverage is available under all WellmarkBlue HMO plans for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, and liver and for certain bone marrow/stem cell transfer transplants.

You should follow written prior approval requirements for all transplants, except kidney.

Note: Transplants are subject to case management.

Other covered services for all plans

General anesthesia and hospital or ambulatory surgical facility services related to the provision of dental services, subject to any other restrictions on dental coverage under your benefits policy, if the member:

- is a child under age 14 who, based on a determination by a licensed dentist and the child's treating Wellmark Health Plan Network provider, has 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
- has, based on a determination by a licensed dentist and the member's treating Wellmark Health Plan Network provider, one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.

Other medically necessary covered services and supplies related to the treatment of illness and injury include:

- Ambulance services (professional air or ground).
- Home infusion therapy.
- Home medical equipment.
- Home skilled nursing if 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, and if coordinated by a case manager.
- Oxygen and equipment administration.
- Prescription drugs and medicines administered in the vein or muscle covered under the Blue Rx Essentials managed prescription drug program.
- Prosthetic devices and braces.

Home health services

Coverage includes care provided by an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency. Services must be prescribed by a Wellmark Health Plan Network provider, approved by our case manager, and is not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

Covered services and supplies include (see limitations on Page 12):

- Home health aide services.
- Home skilled nursing visits if 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, and if coordinated by a case manager.
- Inhalation therapy.
- Medical equipment and supplies.
- Medical social services.
- Prescription drugs and medicines administered in the vein or muscle.
- Occupational therapy to treat the upper extremities.
- Oxygen and equipment for its administration.
- Parenteral and enteral nutrition.
- Physical therapy.
- Prosthetic devices and braces.
- Speech therapy treatment.

Hospice services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include the same services as described under "Home Health Services" as well as hospice respite care from a facility approved by Medicare or 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.

Pediatric vision

Wellmark's pediatric vision benefits are administered through Avesis[1], Wellmark's preferred vision vendor.

Benefits are available for children under age 19. Your deductible is waived for all plans except MyBlue HSA. MyBlue HSA plans will waive the deductible for routine vision exams only. The details:

- One routine vision exam per benefit year at no cost.
- One frame and one pair of lenses per benefit year or contact lenses instead of frames and lenses.
  - Up to $130 for one frame per benefit year (80% coinsurance for covered charges more than $130)
  - Up to $130 per benefit year for non-medically necessary contact lenses (85% coinsurance for covered charges more than $130)
  - Medically necessary contact lenses

[1] *Wellmark's pediatric vision coverage is administered by Avesis, an independent company providing network and claims administration on behalf of Wellmark for pediatric vision benefits.*

Limitations

Your WellmarkBlue HMO coverage is limited as follows:

Cosmetic surgery

Coverage is limited to corrective surgery that has the primary purpose of restoring function lost or impaired as a result of an illness, accidental injury, or birth defect.

Breast reconstruction after a mastectomy

If you have a mastectomy and elect breast reconstruction in connection with the mastectomy, you are covered for 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedemas.

Musculoskeletal treatment

Spinal Manipulation services are limited to a total of 12 self-referred visits per member per benefit period regardless of provider type.

Treatment of mental health conditions and chemical dependency (MH/CD)

Regular follow-up therapy with a behavioral health provider is important after being hospitalized for a mental illness. Research shows follow-up during the first seven days after discharge is critical for good patient outcomes. Working with your behavioral health provider will help sustain the progress you have made and assure medications are managed appropriately. You are encouraged to make or keep an appointment within this timeframe.

It's important to ask your provider to share information with your designated personal doctor, especially if medications are prescribed. The information helps your designated personal doctor coordinate your health care needs, and ensure that medications prescribed by your behavioral health provider don't interfere with other medications.

All plans provide coverage for mental health and chemical dependency treatment subject to these limitations:

- You are not covered for residential treatment of mental health conditions or chemical dependency except:
  - For treatment provided on an intensive outpatient basis, but not including charges related to residential care;
  - For partial hospitalization treatment, but not including charges related to residential care;

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

Occupational, physical and speech therapy

WellmarkBlue HMO plans provide coverage for occupational, speech and physical therapy subject to the benefit terms outlined in your policy:

- Occupational therapy does not cover:
  - Occupational therapy supplies.
  - Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Speech therapy does not cover:
  - 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.
- Physical therapy does not cover:
  - Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
  - Physical therapy performed for maintenance.

Hospice respite care

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 for hospice respite care are limited to:

- 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

Exclusions

The following services are excluded or are not considered medically necessary by Wellmark Health Plan and will not be covered in the WellmarkBlue HMO policies:

Counseling and educational Services

All WellmarkBlue HMO plans exclude coverage for:

- Bereavement counseling or services (including volunteers or clergy)
- Marriage and family counseling

Mental health treatment

- Non-pervasive developmental and learning disorders
- Certain disorders of early childhood (such as academic underachievement disorder)
- Communication disorders (such as stuttering and stammering)
- Impulse-control disorders (such as pathological gambling)
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders
- Applied Behavior Analysis (ABA) services for the treatment of autism and related disorders.
- Treatment in a residential treatment facility, except as described under *Limitations*.

Fertility and infertility

All WellmarkBlue HMO plans exclude coverage for:

- Elective abortion
- Infertility treatment if the infertility is the result of voluntary sterilization.
- The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures or for any other reason or service; freezing of sperm, oocytes, or embryos; surrogate parent services.
- Artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure. If you have any of these procedures done, benefits for all types of fertility or infertility treatment (including drug induced stimulation of ovulation) will end beginning on the day you receive the noncovered service.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Miscellaneous

All WellmarkBlue HMO plans exclude coverage for:

- Anesthesia, local or topical billed separately from a related surgical or medical procedure
- Orthotics
- Purchase of blood (does not apply to members with hemophilia)
- Complications of a non-covered service, supply, device, or drug. (except complications arising from an elective abortion)
- Dental services except as specified and limited in the policy
- Elastic stockings and bandages
- Hearing aids and exams
- Investigational treatment
- Maxillary and mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease
- Motor vehicle special equipments
- Non-medical services
- Personal convenience items
- Rehabilitative speech therapy treatment not provided by a licensed or certified speech pathologist. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.
- Routine vision care for members over age 19
- Services furnished to you prior to the date your policy begins
- Dental extractions, dental restorations, or orthodontic treatments for temporomandibular joint syndrome
- Travel or lodging costs
- Wigs or hairpieces

Organ transplants

All WellmarkBlue HMO plans exclude coverage for:

- Expenses related to purchase of any organ
- Services or supplies related to mechanical or non-human organs associated with transplants
- Transplant services or supplies other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/stem cell transfers
- Expenses of transporting living donor

Provider types

These providers are excluded on all WellmarkBlue HMO plans:

- Provider, if an immediate family member

Covered by other programs or laws

All WellmarkBlue HMO plans exclude coverage for:

- Illness or injury sustained while on active military status
- Services and supplies that are covered or could have been covered under Workers' Compensation laws
- Services or supplies when someone else has the legal obligation to pay for your care or without this health plan, you would not be charged
- Services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid)

Therapy, self-motivation, and other programs

All WellmarkBlue HMO plans exclude coverage for:

- Acupuncture
- Cosmetic services, supplies or drugs if provided primarily to improve physical appearance. A service, supply or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.
- Custodial or sanitaria care or rest cures
- Educational or recreational therapy
- Massage therapy
- Occupational therapy supplies and therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization
- Rehabilitative speech therapy treatment not provided by a licensed or certified speech pathologist. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.
- Self-help or self-cure programs, products, or drugs
- Services and supplies as an inpatient provided primarily for diagnostic evaluation, physical therapy, or occupational therapy
- Weight-reduction programs or supplies

Additional exclusions

- Routine foot care
- Periodic physicals or health examinations, screening or immunization procedures that are performed solely for school, sport, employment, insurance, licensing, or travel

Generally, there are no medical benefits for services received outside of the Wellmark Health Plan Network, except for emergencies or accidental injuries.

Plan overview chart

Generally, there are no benefits for medical services received outside of the Wellmark Health Plan Network, except for emergencies or accidental injuries.

Plan Name	SimplyBlue℠	myBlue HSA℠ [1]			CompleteBlue℠			CompleteBlue Max℠	EnhancedBlue℠		EnhancedBlue Max℠
	5000	2000	3350	5950	2500	3000	4000	5000	500	1250	2750
Metallic Tier	**Bronze**	**Gold**	**Silver**	**Bronze**	**Silver**	**Silver**	**Silver**	**Silver**	**Gold**	**Gold**	**Gold**
Annual Benefit — You Pay											
Single	$5,000	$2,000	$3,350	$5,950	$2,500	$3,000	$4,000	$5,000	$500	$1,250	$2,750
Family[2]	$10,000	$4,000	$6,700	$11,900	$5,000	$6,000	$8,000	$10,000	$1,000	$2,500	$5,500
Coinsurance — You Pay											
In-network providers	50%	0%	0%	0%	30%	30%	40%	0%	20%	20%	0%
Out-of-network providers	Not covered[3]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Annual Benefit — Out-of-Pocket Maximum											
In-network	$6,850/$13,700	$2,000/$4,000	$3,350/$6,700	$5,900/$11,900	$6,700/$13,400	$6,350/$12,700	$6,250/$12,500	$5,000/$10,000	$4,850/$9,700	$3,100/$6,200	$2,750/$5,500
Out-of-network[3]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Services — You Pay											
In-network	$50 copay for PCP; 50% after deductible for non-PCP	Not covered	0% aftert deductible	Not covered	30% coinsurance; (deductible waived)	$35 copay for PCP $70 copay for non-PCP[4]	$40 copay for PCP; $70 copay for non-PCP	$30 copay for PCP; $60 copay for non-PCP[4]	$30 copay for PCP; $60 copay for non-PCP	$20 copay for PCP; $40 copay for non-PCP	$25 copay for PCP; $50 copay for non-PCP[4]
Out-of-network[3]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Inpatient Services/Outpatient Surgery	50% after deductible	0% after deductible	0% after deductible	0% after deductible	30% coinsurance after deductible	30% after deductible	40% coinsurance after deductible	0% after deductible	20% coinsurance after deductible	20% coinsurance after deductible	0% after deductible
Maternity Services	50% after deductible	0% after deductible	0% after deductible	0% after deductible	30% coinsurance after deductible	30% after deductible	40% coinsurance after deductible	0% after deductible	20% coinsurance after deductible	20% coinsurance after deductible	0% after deductible
Emergency Room Care	50% after deductible	0% after deductible	0% after deductible	0% after deductible	$350 copay (waived if admitted)	$350 copay (waived if admitted)	$350 copay (waived if admitted)	$350 copay (waived if admitted)	$250 copay	$300 copay	$300 copay
Preventive Care/Screenings/Immunizations Includes gynecological exam, preventive exam, screening mammography, well-child care and newborn care.[5]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Mental Health & Chemical Dependency Treatment	Covered. Copay, coinsurance or deductible may apply.	Covered. Deductible applies	Covered. Copay, coinsurance or deductible may apply.	Covered. Deductible applies	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.
Laboratory and X-ray Services Includes routine diagnostic lab and X-ray, and advanced radiologic imaging (CT, MRIs, MRAs, PET, nuclear medicine and radiation therapy)	Covered. Copay, coinsurance or deductible may apply.	Covered. Deductible applies	Covered. Copay, coinsurance or deductible may apply.	Covered. Deductible applies	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.	Covered. Copay, coinsurance or deductible may apply.
Spinal Manipulations[6]	$50 copay	0% after deductible	0% after deductible	0% after deductible	30% coinsurance (deductible waive)	$35 copay	$40 copay	$30 copay	$30 copay	$20 copay	$25 copay
Pediatric Dental[7]	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan	Not included in health plan
Pediatric Vision[7]	$130 for one frame per benefit year (80% coinsurance for covered charges above $130) $130 for non-medically necessary contact lenses (85% coinsurance for covered charges above $130)	0% after deductible	0% after deductible	0% after deductible	$130 for one frame per benefit year (80% coinsurance for covered charges above $130) $130 for non-medically necessary contact lenses (85% coinsurance covered charges above $130)						
Prescription Drugs — Blue Rx Essentials℠	0% after deductible	0% after deductible	0% after deductible	0% after deductible	Deductible: Medical/ Tier 1 - $5 (deductible waived for generic) ; Tier 2-$35; Tier 3/Preferred Specialty-$70; Non-Preferred Specialty: 50%	No Deductible/Tier 1- $5; Tier 2-$35; Tier 3/Preferred Specialty-$70; Non-Preferred Specialty: 50%	Deductible: $250 single/$500 family (waived for generics); Tier 1- $5; Tier 2-$35; Tier 3/Preferred Specialty-$70; Non-Preferred Specialty: 50%	Deductible applies (waived for Tier 1) Tier 1: $5 Tier 2, Tier 3/ Preferred specialty, Non-preferred specialty: 0% after deductible	No Deductible/Tier 1- $5; Tier 2-$35; Tier 3/Preferred Specialty-$70; Non-Preferred Specialty: 50%	No Deductible/Tier 1- $5; Tier 2-$35; Tier 3/Preferred Specialty-$70; Non-Preferred Specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50% coinsurance
Contraceptives	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

[1] *Discuss your Health Savings Account (HSA) options with your Wellmark representative.*

[2] *The family deductible can be met through any combination of family members. No one member will be required to meet more than the single deductible amount to receive benefits for covered services during a benefit period. For the myBlue HSA bronze and silver plans, no one member will be required to meet more than the single deductible. For the myBlue HSA gold health plan, the entire family deductible must be met before benefits are payable.*

[3] *Out-of-network services may be covered with Wellmark Health Plan approval.*

[4] *The primary care office copay applies to family practitioners, general practitioners, internal medicine practitioners, obstetricians/gynecologists, pediatricians, physicians assistants and advanced registered nurse practitioners. This lower office copay also applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.*

[5] *HMO designated personal doctor must be seen for preventive care/screenings and immunizations. One preventive exam with separate gynecological exam per member per benefit period. Well-child care up to age 7 (includes normal newborn care, physical examinations, assessments and immunizations).*

[6] *Limit 12 self-referred visits per member, per benefit year.*

[7] *Essential Health Benefit pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19. This policy does not include pediatric dental services as described in the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, producer, or Iowa's Partnership Marketplace Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.*

[8] *No cost share for: generic contraceptive drugs and generic contraceptive drug delivery devices, brand name contraceptive drugs and brand name drug delivery devices when an FDA-approved generic equivalent is not available.*

[9] *Optional supplemental accidental injury benefit can be purchased and added to your medical policy at any time.*

BlueRx Essentials℠ drug coverage

Most prescription drugs are covered under Blue Rx Essentials, your managed drug program. Wellmark Health Plan members must fill their prescriptions through any of the more than 65,000 participating pharmacies nationwide — whether in or out of state — and will have their claims filed electronically by the pharmacy. Specialty drugs must be purchased through the specialty pharmacy program. Blue Rx Essentials Network retail pharmacies as well as specialty pharmacies have point-of-sale computer access to current information to screen for duplicate therapies or interactions with drugs dispensed by other Blue Rx Essentials Network pharmacies.

Blue Rx Essentials℠ Prescription Drug Card Plan

When filling a prescription, it is important to show your Wellmark Health Plan ID card to confirm that the pharmacy participates in the Blue Rx Essentials network. The pharmacist uses this Rx BIN number to file your claims electronically and to determine how much you pay when picking up your prescription. The Rx BIN number is on your Wellmark Health Plan ID card.

The Wellmark Blue Rx Essentials℠ Drug Lists

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

The Wellmark Blue Rx Essentials 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 Wellmark Blue Rx Essentials prescription drug benefits. The Wellmark Blue Rx Essentials 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 Essentials Drug List. You are covered for drugs listed on the Wellmark Blue Rx Essentials 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 Wellmark Blue Rx Essentials 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.

New drugs will not be added to the Drug List until they have been evaluated by Wellmark. We will periodically update the list to reflect these evaluations and to reflect the changing drug market in general. Revisions to the list will be distributed to providers who participate with Wellmark, and pharmacies that participate with the network used by Blue Rx Essentials. Although only drugs listed on the Drug List are covered, Wellmark Health Plan Network providers are not limited to prescribing only the drugs on the list. Wellmark Health Plan Network providers may prescribe any medication, but only medications on the Drug List are covered. A medication on the Drug List will not be covered if the drug is specifically excluded under your prescription drug plan, or other limitations apply. If a drug is not on the Wellmark Blue Rx Essentials Drug List and you believe it should be covered, refer to *Exception Process for Noncovered Drugs*. The Wellmark Blue Rx Essentials Drug List is subject to change.

Understanding drug tiers and what you pay

Drugs are categorized into tiers. The Wellmark Blue Rx Essentials Drug List identifies which tier a drug is on. The tier is also important in determining the amount you pay for your prescriptions.

Blue Rx Essentials

- **Tier 1.** Most generic drugs and some brand-name drugs that have no generic equivalent.
- **Tier 2.** Drugs appear on this tier because they either have no generic equivalent or are considered less cost-effective than Tier 1 drugs.
- **Tier 3.** Drugs appear on this tier because they are less cost-effective than Tier 1 or Tier 2 drugs.
- **Preferred Specialty.** Drugs have 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 without sufficiently documented clinical evidence that they provide a significant benefit over available preferred alternatives.

In most cases, when 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. You will be responsible for your payment obligation for the equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.

Guidelines for drug coverage

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

- Listed on the 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 Wellmark Health Plan Network provider prescribing within the scope of his or her license.
- Dispensed by a recognized, licensed, participating retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program or through the mail order drug program.
- Medically necessary for your condition.
- Reviewed, evaluated, and recommended for addition to the Drug List by Wellmark.

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 that are not covered

Drugs not covered include but are not limited to:

- Drugs not listed on the Wellmark Blue Rx Essentials Drug List.
- Drugs purchased from nonparticipating pharmacies.
- Specialty drugs purchased outside the specialty pharmacy program.
- Drugs in excess of a quantity limitation.
- Drugs that are not FDA approved.
- Experimental or investigational 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.
- 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.
- Irrigation solutions and supplies.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Weight reduction drugs.

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 your Wellmark Health Plan Network provider.
- 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 Wellmark Health Plan Network provider.
- 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.

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 Wellmark Health Plan Network provider. 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 Wellmark Health Plan Network provider, consult the Wellmark Blue Rx Essentials Drug List at Wellmark.com, or call the Customer Service number on your ID card.

Prior authorization of drugs

- Purpose — Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary. In some cases prior authorization may also allow a drug that is normally excluded to be covered if it is part of a specific treatment plan and medically necessary.
- Applies to — Prior authorization is required for a number of particular drugs. Visit Wellmark.com or check with your pharmacist or Wellmark Health Plan Network provider to determine whether prior authorization applies to a drug that has been prescribed for you.
- Person responsible – You are responsible for the prior authorization.
- Process — Ask your Wellmark Health Plan Network provider to call us with the necessary information. If your Wellmark Health Plan Network provider 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. We 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 request prior authorization, you are responsible for paying the entire amount charged.

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 Essentials 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.

Prescription Maximum
30 day retail
90 day retail maintenance
30 day mail order
90 day mail order maintenance
30 day specialty

Mail order drug program

You must purchase mail order drugs through the mail order drug program. You are not covered for mail order drugs purchased outside the mail order drug program. 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. You are not covered for drugs purchased from nonparticipating mail order pharmacies.

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 Blue Rx Essentials prescription drug benefits. To determine whether a particular specialty drug is covered under your Blue Rx Essentials prescription drug benefits, consult the Wellmark Blue Rx Essentials Drug List at Wellmark.com, or call the Customer Service number on your ID card.

Specialty pharmacy program

Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. You must purchase specialty drugs 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. You are not covered for specialty drugs purchased outside the specialty pharmacy program. The specialty pharmacy program administers the distribution of specialty drugs to the home and to physicians' offices.

Preventive items and services

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

Drug company rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services. Drug manufacturers offer rebates to pharmacy benefits managers. Wellmark receives a share of these rebates from its pharmacy benefits manager. Any rebates we receive will be retained by us, and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific claims and they will not be considered when determining your payment obligations.

Exception process for noncovered drugs

- Purpose — You or your prescribing physician may submit an Exception Request for coverage of a non-covered prescription drug by submitting the Exception Request form for non-covered prescription drugs. This form is available at Wellmark.com, or by calling the customer service number on your Wellmark ID card.
- Applies to — Drugs not listed on the Wellmark Blue Rx Essentials Drug List.
- Process — There are two exception processes depending upon whether a noncovered drug has already been purchased or not.
  - If you have not already purchased the noncovered drug:
    - You may call the Customer Service number on your ID card; or
    - You may access the Member Initiated Exception Request Form for Noncovered Pharmaceuticals on our website at Wellmark.com; or
    - You or your Wellmark Health Plan Network provider may follow the prior authorization process described earlier in this section.
  - If you have already purchased the noncovered drug, you will need to contact your Wellmark Health Plan Network provider for details on the medical exception process.
- Importance — If you purchase a drug that is not covered, you are responsible for paying the entire amount charged.

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 Wellmark Health Plan Network provider if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a Wellmark Health Plan Network provider or hospital and the Wellmark Health Plan Network provider or hospital prescribed the prescription drug.

BlueDental℠ Coverage

Dental coverage is available through the Blue Dental Program. This optional coverage offers benefits for diagnostic and preventive care, restorative care, oral surgery, endodontics and periodontics.

When you apply for one of our WellmarkBlue HMO plans, you will have the opportunity to choose Blue Dental coverage. Blue Dental can be purchased and added to your medical policy at any time. It can also be purchased as a stand-alone product.

Blue Dental network

When you're in the Blue Dental service area, which includes the entire state of Iowa, visit a dentist who participates in the dental network.

National Dental GRID network

If you reside or travel outside the Blue Dental service area, you can visit a dentist who is part of the national GRID+ network. The GRID+ network includes more than 82,000 unique dentists.[1] Just show your ID card to the participating dentist or provider to receive the same advantages you receive when visiting a Blue Dental provider.

Covered services

Check-ups and teeth cleaning

- Dental cleaning/prophylaxis
- Oral evaluations
- Periodontal maintenance cleaning
- Space maintainers — for dependent children under age 15
- Topical fluoride applications — for dependent children under the age of 19
- Topical sealant applications — for eligible dependent children under age 15; permanent first and second molars in a lifetime
- X-rays

Cavity repair and tooth extractions

- Emergency treatment for the relief of pain or infection of dental origin
- General anesthesia/sedation billed by the operating dentist for covered oral surgery
- Limited occlusal adjustment
- Restoring decayed or fractured teeth
- Routine and complex extractions

Major restorative (crowns)

- Endodontics — root and pulp treatment
- Periodontics — gum and bone treatment

Exclusions

- Bridges
- Cosmetic procedures
- Dentures
- Implants
- Orthodontics
- Sealants on primary teeth or wisdom teeth

[1] *GRID Dental Corporation (GDC), 2012*

	Your Payment Options
Benefit Year Deductible (Applies to all services except diagnostic and preventive)	$50 Single/$100 Two-person/$150 Family
Benefit Year Maximum	$1,000 per person covered
Diagnostic and Preventive	20% coinsurance
Basic Restorative: Fillings, extractions, oral surgery (6-month waiting period before benefits are available)	20% coinsurance
Major Restorative: Crowns (12-month waiting period before benefits are available)	50% coinsurance
Endodontics (root canals and pulp treatment)	50% coinsurance
Periodontics (gum and bone treatment)	50% coinsurance
Prosthodontics (bridges and dentures)	Not covered

Notification requirements

The following are notification requirements you or your Wellmark Health Plan Network provider should follow to receive the maximum benefits available under your policy.

Precertification

The purpose of precertification is to help determine whether a service or admission to a facility is medically necessary. If you choose to have these services performed even though we were unable to certify the medical necessity of the services, you will be responsible for the charges.

For a complete list of the services subject to precertification, visit Wellmark.com or call the Customer Service number listed on your ID card.

Wellmark Health Plan Network providers obtain precertification for you. However, you or someone acting on your behalf are responsible for precertification if:

- You are admitted to a facility outside Iowa;
- You receive services subject to precertification from a nonparticipating provider.

Concurrent review

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.

For a complete list of the services subject to concurrent review, visit Wellmark.com or call the Customer Service number on your ID card.

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.

Laboratory services, home/durable medical equipment, or prosthetic devices outside the Wellmark Health Plan Network:

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/rented equipment, or shipped equipment. If the provider does not have a contractual relationship with the Blue Plan, that provider will be considered a nonparticipating provider and you will be responsible for the entire amount charged.

Prior approval

Before you receive treatment for certain services, supplies, or procedures, prior approval is required. Prior approval helps determine whether a proposed treatment plan is medically necessary, and is a covered benefit under the policy. Without prior approval for certain services, we cannot confirm that a proposed treatment plan is a benefit of your policy. If prior approval is requested and approved by Wellmark Health Plan, the service will be approved for a specific time period. (Even if you receive prior approval for a service, inpatient admissions may be subject to inpatient admission notification.)

Wellmark Health Plan Network providers request prior approval for you. However, you or someone acting on your behalf are responsible for prior approval if:

- You are admitted to a facility outside Iowa;
- You receive services subject to prior approval from a nonparticipating provider.

For a complete list of services for which prior approval is required, or to ask about any other service, call the phone number listed on your ID card or visit Wellmark.com.

Change of residence

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

Notification

Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination.

Wellmark Health Plan Network providers perform notification for you. However, you or someone acting on your behalf are responsible for notification if:

- You are admitted to a facility outside Iowa.
- You receive services subject to notification from a nonparticipating provider.

For a complete list of services subject to notification, visit Wellmark.com or call the Customer Service number listed on your ID card.

Evaluating the latest technology

At Wellmark Health Plan, we regularly review the latest procedures, drugs, devices, and methods that will improve medical outcomes.

For more information, please call the Customer Service number located on the back of your ID card.

Privacy practices notices

You can visit the following link: Wellmark.com/inform to read more about:

- How your medical information may be used and disclosed.
- How you can get access to information regarding the use of your medical information.
- How you can authorize Wellmark to release your medical information upon approval.

Or call the Customer Service number located on the back of your ID card for questions.

Wellmark's internal protection of Personal Health Information

The steps Wellmark has taken to safeguard members' medical information include, but are not limited to:

a. Disseminated Notice of Privacy Practices to insured members and posted it on the Wellmark website at Wellmark.com.

b. Disseminated a Notice of Privacy Practices and other information practitioners and facilities need to know about Wellmark's privacy practices in the provider newsletter, Blue Ink, and on the Wellmark website.

c. Established a Privacy Office as a primary point of contact concerning questions or issues regarding privacy matters, including toll-free phone access and email address, and published the contact information in the Notice of Privacy Practices on the Wellmark website.

d. Established internal policies and procedures for compliance with the Privacy Rule, and disseminated the information to employees through corporate-wide privacy training, and department-specific training for Customer Service and other areas.

e. As a condition of employment, all members of Wellmark's workforce are required to sign a Confidentiality and Nondisclosure Agreement.

f. In daily interaction with members and providers, Wellmark provider and Customer Service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information.

g. Limited physical and information system access to medical information, only to people who need it to do their jobs.

h. Strict security regarding access to facility, personal computers, and medical information.

General provisions

Eligibility: You are eligible to apply for WellmarkBlue HMO coverage if you reside in the Wellmark Health Plan service area. If you become enrolled in Medicare during the term of this benefits policy, this benefits policy will provide benefits secondary to Medicare unless application of federal law determines this benefits policy must provide benefits primary to Medicare.

If you are applying for child-only coverage, any child(ren) age 20 and under listed on the application is eligible for child-only coverage, or due to a qualifying event that occurs outside of the open enrollment period as long as he/she is not enrolled in or eligible for other coverage[1] at the time of the effective date of coverage.

Reinstatement

- Coverage is automatically renewed by payment of your premium and service fee in advance.
- A grace period of 31 days will be granted for the payment of each premium and fees due after the first premium and fees. During this grace period, your policy will continue in force.
- We may terminate your policy if: (1) you fail to pay your premium when due; (2) you unreasonably refuse to follow a prescribed course of treatment; (3) there is fraudulent use of your policy; or (4) you change your residence from the geographic service area served by Wellmark Health Plan. You must notify us prior to relocating outside the Wellmark Health Plan Service area, as you will have no benefits for services except for emergencies or accidental injuries.
- When you no longer qualify as a dependent or spouse under this policy, you may obtain conversion coverage from Wellmark Blue Cross and Blue Shield of Iowa if you apply for a plan within 31 days of the date you become ineligible for this policy.

Medicare eligibility

When you become eligible for Medicare, you may convert to a Wellmark Blue Cross and Blue Shield of Iowa Medicare supplement plan without answering health questions if you still reside in Iowa, and you have Medicare Parts A and B, and you apply during your six-month guaranteed enrollment period.

Medicare enrollment

If you become enrolled in Medicare during the term of this benefits policy, this benefits policy will provide benefits secondary to Medicare unless your employer contributes toward the premiums or otherwise sponsors this benefits policy in which case this benefits policy may be required by federal law to provide benefits primary to Medicare.

Subrogation

Once you receive benefits under your WellmarkBlue HMO policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to that illness or injury. We will assume all rights for recovery, to the extent of our payment, regardless of whether our payment is made before or after settlement of any third-party claim, and regardless of whether you have received full or complete compensation for any injury or illness. You and your covered family member(s) agree to notify us if you have the potential right to receive payment from someone else and to cooperate with us to ensure that our rights to subrogation are protected. We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

Coordination of benefits

Coordination of benefits applies when you have more than one insurance policy or plan that provides the same or similar benefits as this policy, including other individual or group sponsored coverage in which you are enrolled.

Benefits payable under this policy, 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.

Notwithstanding the foregoing provisions on Coordination of Benefits, Wellmark Health Plan will always pay as though it is the primary carrier when you use your ID card for prescription drugs purchased at a pharmacy.

Other information

- A reduced premium rate is available for persons who do not currently use tobacco products and have not used tobacco products for a minimum of 12 consecutive preceding months.
- Premium rates for a specified individual are determined by the base premium rate for the block of business that reflects the actual and anticipated experience for all policies included in the block. Base premium rates are adjusted to reflect the particular benefit plan chosen as well as age, and tobacco use.

[1] *Other coverage includes Group Health coverage or other creditable coverage (not including HIPIOWA, Medicaid, or hawk-i)*

Health and wellness programs

Helping you maintain or improve your health is important. That's why Wellmark Health Plan is more than just a health insurance company — we are people helping people. In support of your health care coverage, we provide programs and services with your health and wellness needs in mind.

Personal Health Assistant 24/7

Getting answers to health care questions just got easier. By calling a toll-free hotline, we can provide a direct connection to specially trained health professionals who can provide tools and support your needs.

- Care Navigation 24/7 — provides help in locating health care resources and understanding medical treatments.
- Decision Support 24/7 — provides support to assist you in making wise health care decisions.
- Nurse Support 24/7 — provides advice on urgent care concerns.

Blue365®

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

You'll find substantial savings and helpful information in these categories:

- Health and wellness — referrals and savings on elective procedures, such as laser vision correction surgery, discounts on weight-loss programs like Jenny Craig,® and fitness clubs like SNAP Fitness.™
- Family care — support and information for parents or dependents in need of caregiver services.
- Financial well-being — access to help planning for your future.
- Travel — discounts on healthy vacations, lodging like Westin Hotels, destination-specific travel tips, and assistance with passport issues and inquires.

Pregnancy Care program

Our Pregnancy Care program provides valuable information and support for moms-to-be and new mothers, from the first trimester through the early weeks of parenthood. This program provides resources to help all expecting mothers better understand and manage their pregnancy. The goal is to help moms-to-be avoid complications and preterm birth, as well as provide nurse support for high-risk pregnancies.

Complex Case Management program

Our Complex Case Management program is designed to provide you with long-term health care needs resulting from extreme illness or injury. You, your Wellmark Health Plan Network provider, and the hospital work with our case managers to identify and arrange treatment plans in an effort to meet your special needs and to assist in preserving your health insurance benefits.

Wellmark Health Plan may from time to time make available to you certain health support services for a fee or for no fee. Wellmark Health Plan may offer financial and other incentives to you to use such services. As part of the provision of such services, Wellmark Health Plan may: (1) use your personal health information (including but not limited to: substance abuse, mental health, and AIDS/HIV information), and (2) disclose such information to your health care providers and Wellmark Health Plan's vendors, for purposes of providing such services to you. When using such information, Wellmark Health Plan will do so according to the terms of Wellmark's Privacy Practices Notices, which can be accessed at Wellmark.com/footer/HIPAA-AS.aspx. Wellmark Health Plan may also, from time to time, make available to you certain value-added benefits for a fee or no fee. Examples include, discounts on alternative/preventive therapies, fitness, exercise and diet assistance and elective procedures, as well as resources to help you make more informed health decisions.

Terms to know

Deductible

The fixed dollar amount you pay for most covered services before benefits are available during a benefit period. There are single and family deductibles.

Family deductible

This can be met through any combination of family members. No one member will be required to meet more than the single deductible amount before he or she receives benefits for a covered service during a benefit period.

For the myBlue HSA bronze and silver plans, no one member will be required to meet more than the single deductible. For the myBlue HSA gold health plan, the entire family deductible must be met before benefits are payable.

Coinsurance

The amount, calculated using a fixed percentage, you pay each time you receive services. Your coinsurance is based on the payment arrangement amount minus deductible and contract limitations for all covered services provided by Wellmark Health Plan Network providers.

Copayments

Specific dollar amounts you pay at the time you receive covered services.

Out-of-pocket maximum (OPM)

The amount you pay out of your pocket for most covered services during a benefit period. The deductible, copayment and coinsurance provisions, specific to your medical coverage, apply toward meeting the OPM. For HSA plans, the deductible, coinsurance, and applicable drug copayments apply toward meeting the OPM.

Wellmark Health Plan Network savings

The amount saved due to contracts Wellmark Health Plan has with providers.

Payment arrangement

Wellmark Health Plan 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 — 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 — Reflects the portion of provider charges not covered under this health plan and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a service maximum, benefit year maximum, or lifetime benefits maximum; reductions or denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider.
- Amount Paid by Health Plan — 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

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 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. Network providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

This is a general description of coverage for non-grandfathered plans. It is not a statement of contract. Actual coverage is subject to the terms and conditions specified in the policy itself and enrollment regulations in force when the policy becomes effective.

If you have questions or need additional information:

Please call your agent or Wellmark Health Plan of Iowa, Inc.

Wellmark® Health Plan of Iowa

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