

Notice

The official Plan Document that describes the benefits for which you are eligible under your group health plan is available, in print, in the department of your employer or group sponsor responsible for the administration of your health plan. A printed copy of the Coverage Manual further describing benefits for which you are eligible under your group health plan is also available, upon your request, from the department of your employer or group sponsor responsible for the administration of your health plan.

This notice is attached to an electronic copy of the Coverage Manual for your group health plan. Wellmark Blue Cross and Blue Shield of Iowa is not responsible for any alterations or modifications that may be made to an electronic copy or other differences that may exist between the attached electronic copy of the Coverage Manual and the printed Coverage Manual. Any alterations, modifications, or differences contained in the electronic copy to which this Notice is attached that are not consistent with, or that conflict with, the printed Coverage Manual issued to your employer or group sponsor are not binding on Wellmark Blue Cross and Blue Shield of Iowa. In the event of any inconsistency or conflict between the printed Coverage Manual and an electronic copy, the terms of the printed Coverage Manual shall govern.



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

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The Educators Group

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Contents

About This Coverage Manual.....	1
1. What You Pay	3
Payment Summary.....	3
Payment Details	3
2. At a Glance - Covered and Not Covered	7
3. Details - Covered and Not Covered	11
4. General Conditions of Coverage, Exclusions, and Limitations.....	23
Conditions of Coverage.....	23
General Exclusions	24
Benefit Limitations.....	25
5. Choosing a Provider.....	27
6. Notification Requirements and Care Coordination	29
7. Factors Affecting What You Pay	35
8. Coverage Eligibility and Effective Date.....	39
Eligible Members.....	39
When Coverage Begins	39
Preexisting Condition Exclusion Period	39
Prior Creditable Coverage.....	40
Qualified Medical Child Support Order	41
9. Coverage Changes and Termination.....	43
Coverage Change Events.....	43
Requirement to Notify Group Sponsor.....	43
Coverage Termination.....	44
Certificate of Creditable Coverage.....	45
Coverage Continuation	45
10. Claims.....	47
When to File a Claim.....	47
How to File a Claim	47
Notification of Decision.....	48
11. Coordination of Benefits.....	49
Other Coverage.....	49
Claim Filing	49
Rules of Coordination.....	49
Coordination with Medicare	51
12. Appeals.....	53
Right of Appeal.....	53
How to Appeal.....	53
Where to Send Appeal.....	53
Review of Appeal	53
Decision on Appeal	54
Legal Action	54
External Review Process	54

13. Your Rights Under ERISA	55
14. General Provisions	57
Contract.....	57
Interpreting this Coverage Manual.....	57
Authority to Terminate, Amend, or Modify	57
Authorized Group Health Plan Changes.....	57
Authorized Representative.....	57
Release of Information	58
Privacy of Information	58
Member Health Support Services	58
Value Added or Innovative Benefits.....	59
Nonassignment	59
Governing Law	59
Legal Action	59
Medicaid Enrollment.....	59
Subrogation.....	59
Workers' Compensation.....	61
Payment in Error	61
Premium.....	61
Notice	62
Glossary.....	63
Index	65

About This Coverage Manual

Contract

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

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

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

Charts

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

Complete Information

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

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

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

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

Read Thoroughly

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

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

Questions

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

1. What You Pay

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

Payment Summary

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

Category	You Pay
Deductible	\$100 per person \$200 (maximum) per family*
Coinsurance	10% for covered services received from PPO providers. 20% for covered services received from participating and nonparticipating providers.**
Out-of-Pocket Maximum	\$500 per person \$500 (maximum) per family*

*Family amounts are reached from amounts accumulated on behalf of any combination of family members.

**Participating and nonparticipating providers are non-PPO. See *Choosing a Provider*, page 27.

Payment Details

Deductible

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

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

Once you meet the deductible, then coinsurance applies.

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

If a family member is removed from your coverage during the benefit year and this changes your coverage type from family to single coverage, you will not be credited with deductible amounts that were paid during the benefit year on behalf of the

removed family member. As of the date of the coverage change, you will be responsible for any applicable deductible that remains unmet in the absence of amounts that were paid on behalf of the removed family member. See *Coverage Changes and Termination*, page 43.

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.

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 35. Coinsurance amounts apply after you meet the deductible.

Wellmark does not have contracts with retail pharmacies. Therefore, covered prescription drugs and medicines purchased from retail pharmacies are subject to the participating and nonparticipating coinsurance.

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.
- Certain coinsurance amounts.

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

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Mammograms received from PPO providers.	Deductible

If a family member is removed from your coverage during the benefit year and this changes your coverage type from family to single coverage, you will not be credited with out-of-pocket maximum amounts that were paid during the benefit year on behalf of the removed family member. As of the date of the coverage change, you will be responsible for any applicable out-of-pocket maximum that remains unmet in the absence of amounts that were paid on behalf of the removed family member. See *Coverage Changes and Termination*, page 43.

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 23.
- Coinsurance amounts you pay for the treatment of infertility.

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

Lifetime Benefits Maximum

This is the maximum payment amount each member is eligible to receive for certain covered services in his or her lifetime.

Lifetime benefits maximum amounts are accumulated from claim payment amounts under this medical benefits plan and prior medical benefits plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Covered Service	Payment Obligation Waived
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services.	Deductible
Office services received from PPO practitioners. Some lab testing performed in the office may be sent to a provider that is not a PPO provider for processing. When this happens, your deductible and coinsurance may apply.	Deductible
Outpatient preventive care received from PPO providers.	Deductible
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
Well-child care.	Deductible
X-ray and lab services billed by PPO facilities in the Wellmark service area and interpretations by PPO practitioners in the Wellmark service area when your practitioner sends you to the outpatient department of a PPO facility.	Deductible
<p>For a description of the Wellmark Service area, see <i>Choosing a Provider</i>, page 27. The deductible is not waived for the following services: CT (computerized tomography) scans, MRAs (magnetic resonance angiography), MRIs (magnetic resonance imaging), PET (positron emission tomography) scans, nuclear medicine, ultrasounds, and radiation therapy.</p>	

2. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this coverage manual. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 11. To fully understand which services are covered and which are not, you must become familiar with this entire coverage manual. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

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

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

Not Covered. The listed category is generally not covered.

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

Service Maximum. This column lists maximum benefit amounts that each member is eligible to receive per covered service, benefit year, or lifetime. Service maximums that apply per benefit year or per lifetime are reached from claim payment amounts accumulated under this group health plan and any prior group health plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Category	Covered	Not Covered	See Page	Service Maximum
Acupuncture Treatment		⊘	11	
Allergy Testing and Treatment	●		11	
Ambulance Services	●		11	
Anesthesia	●		11	
Blood and Blood Administration	●		11	
Chemical Dependency Treatment	●		11	30 days per benefit year for inpatient treatment. 60 visits per benefit year for outpatient treatment. Mental health services are also included in the above service maximums.
Chemotherapy and Radiation Therapy	●		11	
Cosmetic Services		⊘	11	
Counseling Services		⊘	12	
Dental Treatment for Accidental Injury	●		12	
Dialysis	●		12	

Category	Covered	Not Covered	See Page	Service Maximum
Education Services for Diabetes	●		12	10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour annually.
Emergency Services	●		13	
Fertility and Infertility Services	●		13	\$25,000 per lifetime for covered services and supplies related to infertility treatment.
Genetic Testing	●		13	
Hearing Services (related to an illness or injury)	●		13	
Home Health Services	●		14	
Home/Durable Medical Equipment	●		15	
Hospice Services	●		15	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	●		15	
Illness or Injury Services	●		16	
Inhalation Therapy	●		16	
Maternity Services	●		16	
Medical and Surgical Supplies	●		16	
Mental Health Services	●		17	30 days per benefit year for inpatient treatment. 60 visits per benefit year for outpatient treatment. Chemical dependency services are also included in the above service maximums.
Morbid Obesity Treatment	●		17	
Motor Vehicles		⊖	18	
Musculoskeletal Treatment	●		18	
Nonmedical Services		⊖	18	
Occupational Therapy	●		18	
Orthotics	●		18	
Over-the-Counter Products		⊖	18	
Physical Therapy	●		18	
Physicians and Practitioners			18	
Advanced Registered Nurse Practitioners	●		18	
Audiologists	●		19	
Chiropractors	●		19	
Doctors of Osteopathy	●		19	

Category	Covered	Not Covered	See Page	Service Maximum
Licensed Independent Social Workers	●		19	
Medical Doctors	●		19	
Occupational Therapists	●		19	
Optometrists	●		19	
Oral Surgeons	●		19	
Physical Therapists	●		19	
Physician Assistants	●		19	
Podiatrists	●		19	
Psychologists	●		19	
Speech Pathologists	●		19	
Prescription Drugs	●		19	
Preventive Care	●		20	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year.
Prosthetic Appliances	●		20	
Reconstructive Surgery	●		21	
Self Help Programs		⊖	21	
Sleep Apnea Treatment	●		21	
Speech Therapy	●		21	
Surgery	●		21	
Temporomandibular Joint Disorder (TMD)	●		21	
Transplants	●		21	\$10,000 per operation for costs associated with a member's transportation in an ambulance to a transplant center.
Travel or Lodging Costs		⊖	22	
Vision Services	●		22	One routine vision examination per benefit year.
Wigs or Hair Pieces		⊖	22	
X-ray and Laboratory Services	●		22	

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this coverage manual. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 23. If a service or supply is not specifically listed, do not assume it is covered.

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

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

All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

See Also:

Transplants later in this section.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Blood and Blood Administration

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

Chemical Dependency Treatment

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

Service Maximum:

- **30 days** per benefit year for inpatient treatment.
- **60 visits** per benefit year for outpatient treatment.

Mental health services are also included in the service maximums above.

Not Covered:

- Residential facility services.

See Also:

Hospitals and Facilities later in this section.

Chemotherapy and Radiation Therapy

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

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a

birth defect including treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling Services

Not Covered: Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.

See Also:

Genetic Testing later in this section.

Mental Health Services later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:
 - Treatment is completed within 12 months of the injury.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
 - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
 - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an outpatient. Inpatient removal is covered only when you have a medical condition

(such as hemophilia) that requires hospitalization.

- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, cast restorations, dentures and bridges, and orthodontic services.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration).

Dialysis

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

Education Services for Diabetes

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

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

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

Service Maximum:

- **10 hours** of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour 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 PPO provider, covered services will be reimbursed as though they were received from a PPO provider.

However, because we do not have contracts with nonparticipating providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

See Also:

Nonparticipating providers, page 36.

Fertility and Infertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
- Infertility testing and treatment including in vitro fertilization, gamete intrafallopian transfer (GIFT), and pronuclear stage transfer (PROST).

Service Maximum:

- **\$25,000** per lifetime for covered services and supplies related to infertility treatment.

Not Covered:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

See Also:

Prescription Drugs later in this section.

Prior Approval, page 30.

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.

See Also:

Prior Approval, page 30.

Hearing Services

Covered:

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

Not Covered:

- Hearing aids.
- Routine hearing examinations.

Home Health Services

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

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

The following are covered services and supplies:

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

Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. The daily benefit for home skilled nursing services will not exceed the daily rate for a comparable level of care in a facility setting, and annual benefits will not exceed the total amount we would pay in one year for a

comparable level of care in a facility setting. Home skilled nursing will be coordinated by a case manager. Custodial care is not included in this benefit.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Appliances and Braces.

Speech Therapy.

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

See Also:

Case Management, page 31.

Precertification, page 29.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

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

See Also:

Medical and Surgical Supplies later in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Prior Approval, page 30.

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. Hospice care must be precertified.

Service 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.

See Also:

Precertification, page 29.

Hospitals and Facilities

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

Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.

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

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

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

Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

Not Covered:

- Residential Treatment Facility. This type of facility provides treatment for severe, persistent, or chronic mental health conditions or chemical dependency that meets all of the following criteria:
 - Treatment is provided in a 24-hour residential setting.
 - Treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision.
 - Treatment includes training in basic skills such as social skills and activities of daily living.
 - Treatment does not require daily supervision of a physician.

Illness or Injury Services

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

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

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

See Also:

Precertification, page 29.

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.

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.

See Also:

Coverage Change Events, page 43.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Insulin syringes and supplies.
- Trusses.

Not Covered:

- Elastic stockings or bandages including lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Prescription Drugs later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Recognized facilities for mental health services include licensed and accredited community mental health centers that provide mental health services on an outpatient basis.

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

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

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

- The disorder is listed only as a mental health condition in the most current “International Classification of Diseases, Ninth Revision, Clinical Modification” (ICD-9-CM) and not dually listed elsewhere in the ICD-9-CM.
- The disorder is not a chemical dependency condition.

Service Maximum:

- **30 days** per benefit year for inpatient treatment.
- **60 visits** per benefit year for outpatient treatment.

Chemical dependency services are also included in the service maximums above.

Not Covered:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nicotine dependence.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual identification or gender disorders.
- Residential facility services.

See Also:

Hospitals and Facilities earlier in this section.

Morbid Obesity Treatment

Covered: Weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this coverage manual, or call the Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number on your ID card or visit our Web site at www.wellmark.com.

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.

See Also:

Prior Approval, page 30.

Motor Vehicles

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

Musculoskeletal Treatment

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

Not Covered: Massage therapy.

Nonmedical Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, and educational or recreational therapy or services or supplies that are nonmedical.

Occupational Therapy

Covered: Services are covered, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Orthotics

Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Over-the-Counter Products

Not Covered: Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products 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.

Physical Therapy

Covered.

Not Covered: Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

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.

Not Covered:

- Athletic Trainers.

See Also:

Choosing a Provider, page 27.

Prescription Drugs

Covered:

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

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

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

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

Additional prescription drugs and medicines covered under this medical benefits plan include:

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

- Contraceptive devices.
- Contraceptives absorbed through the skin.
- Implanted contraceptives.
- Injected contraceptives.
- Oral contraceptives.

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

Insulin.

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

Self-Administered Injectable Drugs. Self-administered injectable drugs are generally covered under this medical benefits plan.

Not Covered:

- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Prescription drugs and devices used to treat nicotine dependence, including related medical evaluations, psychotherapy, and x-ray and lab services.

See Also:

Medical and Surgical Supplies earlier in this section.

Prior Authorization, page 32.

Preventive Care

Covered:

- Physical examinations and related preventive services such as:
 - Gynecological examinations.
 - Immunizations.
 - Mammograms.
 - Pap smears.
- 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.

Service Maximum:

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

Not Covered:

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

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Appliances

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 appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

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:

Prior Approval, page 30.

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.

See Also:

Prior Approval, page 30.

Speech Therapy

Covered: Rehabilitative speech therapy treatment.

Not Covered:

- Speech therapy services not coordinated through home health services when the services are received through a home health agency.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

See Also:

Prior Approval, page 30.

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.

Temporomandibular Joint Disorder (TMD)

Covered.

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

Transplants

Covered:

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

Transplants are subject to Case Management.

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

Service Maximum:

- **\$10,000** per operation for costs associated with a member's transportation in an ambulance to a transplant center.

Not Covered:

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

See Also:

Prior Approval, page 30.

Case Management, page 31.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Routine vision examinations.

Service Maximum:

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

Not Covered:

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

- Eye examinations for the fitting of eyewear.

Wigs or Hair Pieces

Not Covered.

X-ray and Laboratory Services

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

See Also:

Preventive Care earlier in this section.

4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

Medically Necessary

A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
 - Any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and

considered effective for the patient's illness, injury or disease.

- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

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

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

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

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the PPO 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 Wellmark service area that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Member Eligibility

Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 39.

General Exclusions

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

Investigational or Experimental

You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine.

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

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

- The health improvement is attainable outside the investigational settings.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual 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. Copies of the evaluation criteria and the reference manual information for a specific service, supply, device, or drug are available upon request.

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

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

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the PPO 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 Wellmark service area that Wellmark determines to be investigational or experimental. This is

true even if the provider does not give you any written notice before the services are rendered.

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.

Nonmedical Services

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

Personal Convenience Items

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

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

Provider Is Family Member

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

Covered by Other Programs or Laws

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

- You are entitled to claim benefits from a governmental program (other than Medicaid).

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

Workers' Compensation

You are not covered for services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

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

Benefit Limitations

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

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a service maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 11.
- If you receive total benefits in an amount that reaches a lifetime benefits maximum, you are no longer eligible for benefits under this group health plan. See *Lifetime Benefits Maximum*, page 4,

and *At a Glance—Covered and Not Covered*, page 7.

- If you do not obtain precertification for medical services, benefits can be reduced or denied. You are responsible for these benefit reductions only if you are responsible (not your provider) for notification. A PPO provider will handle notification requirements for you. See *Notification Requirements and Care Coordination*, page 29.
- If you do not obtain prior authorization for prescription drugs, benefits can be reduced or denied. See *Notification Requirements and Care Coordination*, page 29.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 27, and *Factors Affecting What You Pay*, page 35. Examples of charges that depend on the type of provider include but are not limited to:
 - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from a nonparticipating provider.

5. Choosing a Provider

This medical benefits plan is called Alliance Select.

It relies on a preferred provider organization (PPO) network, which consists of providers that participate directly with Alliance Select and providers that participate with other Blue Cross and/or Blue Shield preferred provider organizations (PPOs). These PPO providers offer services to members of contracting medical benefits plans at a reduced cost, which usually results in the least expense for you.

Non-PPO providers are either participating or nonparticipating. If you are unable to utilize a PPO provider, it is usually to your advantage to visit what we call a *participating provider*. Participating providers participate with a Blue Cross and/or Blue Shield Plan, but not with a PPO.

Other providers are considered nonparticipating, and you will usually pay the most for services you receive from them.

See *What You Pay*, page 3 and *Factors Affecting What You Pay*, page 35.

To determine if a provider participates with this medical benefits plan, ask your

provider, visit our Web site at www.wellmark.com, or www.bcbs.com, refer to your provider directory (a separate document that's available, without charge), or call **800-810-BLUE**.

For types of providers that may be covered under this medical benefits plan, see *Hospitals and Facilities*, page 15 and *Physicians and Practitioners*, page 18.

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

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

Pharmacies do not participate with Alliance Select.

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

*If you visit a PPO provider outside the Wellmark service area, you are responsible for notification requirements. See *Services Outside the Wellmark Service Area* later in this section.

Services Outside the Wellmark Service Area

Whenever possible, before receiving services outside the Wellmark service area, you should ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate PPO providers in any state, call **800-810-BLUE**, or visit *www.bcbs.com*.

Iowa and South Dakota comprise the Wellmark service area.

BlueCard Program. We participate with other Blue Cross and Blue Shield Plans in a national program called the BlueCard Program. This program ensures that members of any Blue Plan have access to the advantages of PPO providers throughout the United States.

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a BlueCard PPO 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.

BlueCard PPO providers contract with the Blue Cross and/or Blue Shield preferred provider organization (PPO) in their home state.

When you receive covered services from BlueCard providers outside the Wellmark service area, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.

- The health plan payment is sent directly to the providers.

When you receive covered services from BlueCard providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 29.

Care in a Foreign Country

For covered services you receive in a country other than the United States, payment level assumes the provider category is nonparticipating except for services received from providers that participate with BlueCard Worldwide.

6. Notification Requirements and Care Coordination

Many services require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical.

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 plan in effect at the time of your request. If your coverage changes for any reason, you may be required to repeat the notification process.

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 53. Also see *Authorized Representative*, page 57.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. This notification requirement is mandatory; however, it does not apply to maternity or emergency services.
Applies to	Acute Rehabilitation Facilities Home Health Services Home Infusion Therapy Hospice Services Nursing Facilities Facilities Outside Iowa or South Dakota
Person Responsible	PPO providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for notifying us if: <ul style="list-style-type: none">■ You are admitted to a facility outside Iowa or South Dakota;■ You receive any of the services listed above from a participating or nonparticipating provider.
Process	When you, instead of your PPO provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: <ul style="list-style-type: none">■ 72 hours in a medically urgent situation;■ 15 days in a non-medically urgent situation.

Importance	<p>If you choose to obtain any service subject to precertification even though we were unable to certify its medical necessity, you will be responsible for the charges.</p> <p>Even if a service is medically necessary and otherwise covered, without precertification, benefits will be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed \$500 per admission. See <i>Maximum Allowable Fee</i>, page 37. You are subject to this benefit reduction only if you (instead of your PPO provider) are responsible for notification.</p> <p>Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See <i>What You Pay</i>, page 3.</p>
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Prior Approval

Purpose	<p>Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical plan before you receive services. This notification is recommended.</p>
Applies to	<p>The most common services for which we recommend prior approval include, but are not limited to, the following list. For a complete list of services subject to prior approval, visit www.wellmark.com or call the Customer Service number on your ID card.</p> <ul style="list-style-type: none"> Genetic Testing Home/Durable Medical Equipment Infertility Procedures including all forms of in vitro fertilization Obstructive Sleep Apnea Treatment Reconstructive Surgery Speech Therapy Transplants Weight Reduction Surgery
Person Responsible	<p>PPO providers request prior approval for you. You are responsible for prior approval if you receive the care from a participating or nonparticipating provider.</p>
Process	<p>When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.</p> <p>Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request by mailing the decision to the most current address on record for both you and your provider within:</p> <ul style="list-style-type: none"> ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation.

Importance	<p>If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and service 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, it may not be covered.</p> <p>Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits plan 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 a new medical benefits plan), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.</p> <p>Note: An admission to a facility outside Iowa or South Dakota to receive a service for which prior approval is recommended is also subject to precertification. See <i>Precertification</i> earlier in this section.</p>
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Continued Stay Review

Purpose	Continued stay review helps determine whether ongoing care is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	<p>Inpatient Facility Admission</p> <p>Home Health Services</p> <p>Home Infusion Therapy</p> <p>Hospice Services</p>
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary.
Importance	<p>Wellmark may require a change in the level or place of service in order to continue providing benefits.</p> <p>If we determine that your current 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.</p>

Case Management

Purpose	Case management is a process of considering alternative treatments for members with severe illnesses or injuries that require costly, long-term care. Depending on the individual circumstances, a hospital may not be the most appropriate setting for treatment.
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Applies to	<p>Examples where case management might be appropriate include but are not limited to:</p> <ul style="list-style-type: none"> Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Home Health Services Pregnancy (high risk) Transplants
Person Responsible	<p>You, your physician, and the health care facility can work with Wellmark's case managers to identify and arrange alternative treatment plans to meet special needs. Wellmark may initiate a request for case management.</p>
Process	<p>Wellmark's case managers try to identify alternative settings or treatment plans, provided costs do not exceed those of an inpatient facility. A benefit program is tailored to the circumstances of the case.</p> <p>Even if a service is not covered or is subject to a specific limitation, Wellmark may waive exclusions or limitations with the agreement of its medical director.</p> <p>If your current level or setting of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified at least 24 hours before benefits end.</p>
Importance	<p>Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.</p>

Prior Authorization of Drugs

Purpose	<p>Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary.</p> <p>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.</p>
Applies to	<p>Prior authorization is required for a number of particular drugs. Visit www.wellmark.com or check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.</p>

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 request prior authorization, you are responsible for paying the entire amount charged.

7. Factors Affecting What You Pay

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

Benefit Year

A benefit year is the same as a calendar year and starts over each January 1. It continues even if you change benefits under the medical benefits plan sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

If you are an inpatient in a covered facility on the date your benefit year renews, your benefit limitations and payment obligations for facility services will also renew and will be based on the amounts in effect on the date you were admitted. However, your payment obligations for practitioner services will be based on the amounts in effect on the day you receive services.

The benefit year is important for calculating:

- Deductible.
- Coinsurance.
- Out-of-pocket maximum.
- Service 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.

PPO Providers in the Wellmark Service Area and All Participating and Nonparticipating Providers

Excluding PPO office and independent lab services, 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 23.

PPO Providers' Office and Independent Lab Services

For covered services you receive in the office of PPO practitioners in the Wellmark service area, or independent lab services received from PPO providers in the Wellmark service area, coinsurance is calculated using the amount charged after the following amounts (if applicable) are subtracted from it:

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

BlueCard PPO Providers Outside the Wellmark Service Area

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

- The amount charged for the covered service, or
- The payment arrangement or negotiated price that the local Blue Cross or Blue Shield Plan passes on 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 23.

Often, the payment arrangement or negotiated price consists of a simple discount that reflects the actual price paid by the local Blue Plan. Sometimes, it is an estimated price that factors in expected settlements, withholds, and other

contingent payment arrangements and non-claims transactions with the health care provider or a specific group of providers. The payment arrangement or negotiated price may also be charged amounts reduced to reflect an average expected savings with the provider or group of providers. A price that reflects average savings may result in greater variation from the actual price paid than will an estimated price. The payment arrangement or negotiated price may also be adjusted in the future to correct for over- or under-estimates of past prices; however, the amount you pay is considered a final price.

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

Statutes in a few states may require the local Blue Plan to use a basis for calculating your payment obligation for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. In such a case, Wellmark would calculate your payment obligation in accordance with the applicable state statute in effect at the time you received your care. For more information, see *BlueCard Program*, page 28.

PPO Providers

Blue Cross and Blue Shield Plans have contracting relationships with PPO providers. When you receive services from PPO providers:

- The PPO amounts for the following are waived for certain covered services. See *Waived Payment Obligations*, page 4.
 - Deductible.
- The PPO amounts for the following are less than the participating and nonparticipating amounts.
 - Coinsurance.
- These providers agree to accept Wellmark's payment arrangements or payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Nonparticipating Providers

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

- You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by a nonparticipating provider may be the lesser of Wellmark's maximum allowable fee or the amount allowed by the Blue Cross or Blue Shield Plan in the state where the provider is located. See *Services Outside the Wellmark Service Area*, page 28.
- Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.
- The health plan payment for nonparticipating hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider (plus any billed balance you may owe).

Amount Charged and Maximum Allowable Fee

Amount Charged

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

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 PPO 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 PPO 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 facility could be different from the covered charge. Regardless of the amount we pay a facility, 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 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 for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
 - Deductible.
 - Coinsurance.
 - Amounts representing any general exclusions and conditions.
 - Network savings.

Payment Method for Services

Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. 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. PPO 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.

Wellmark Drug List

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

effective for a wide range of health conditions.

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

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our Web site, www.wellmark.com.

The Wellmark Drug List is subject to change.

Special Programs

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

Visit our Web site at www.wellmark.com or call us to determine whether your prescription qualifies.

Drug Company Rebates

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 group or to your specific claims and they will not be considered when determining your payment obligations.

8. Coverage Eligibility and Effective Date

Eligible Members

You are eligible for coverage if you meet your employer's or group sponsor's eligibility requirements. Also eligible for coverage is an eligible member's spouse or domestic partner.

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

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

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

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

- Under age 25.
- A full-time student enrolled in an accredited educational institution. Full-time student status continues during regularly scheduled school vacations and during extended absences for up to four months due to a physical or mental disability.
- Totally and permanently disabled, physically or mentally. The disability must have existed before the child

turned age 25, or while the child was a full-time student. In addition, the child must have had creditable coverage without a break of 63 days or more since turning age 25 or since becoming a full-time student.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 43.

When Coverage Begins

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

Preexisting Condition Exclusion Period

You may be required to wait a specified time from your enrollment date before benefits are available for any medical services you receive for a preexisting condition. See *Duration of Exclusion Period* later in this section.

Preexisting Condition

A preexisting condition is an illness, injury, medical, surgical, or other condition for which medical advice, diagnosis, or treatment was recommended or received within the six months ending on your enrollment date. Pregnancy is not considered a preexisting condition.

When Exclusion Period Applies

A preexisting condition exclusion period applies if the member has a preexisting condition and:

- The member enrolls as a late enrollee. A late enrollee is a member who declines coverage when initially eligible to enroll and then later enrolls 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 43.

When a preexisting condition exclusion period applies, it begins on the enrollment date.

Late Enrollee: If a member is a late enrollee, the enrollment date is the date the member signed the application for coverage.

Duration of Exclusion Period

The preexisting condition exclusion period is 18 consecutive months from the enrollment date, minus any period of prior creditable coverage.

Prior Creditable Coverage

Prior creditable coverage reduces the preexisting condition exclusion period by the amount of time you had the prior coverage provided there was no break in coverage of 63 days or more. For instance, if you were covered by another medical benefits plan (without a break of 63 days or more) for the three-month period before your enrollment date under this medical benefits plan, and if this plan includes a 12-month preexisting condition exclusion period, your preexisting condition exclusion period would be reduced to nine months.

If you have a newborn child or adopt a child prior to being covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if he or she had prior creditable coverage at birth or on the date of placement for adoption (without a break in coverage of 63 days or more).

If you have a newborn child or adopt a child while you are covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if you add him or her to your coverage within 60 days of birth, adoption, or placement in your home for adoption.

Creditable coverage means any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

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

You have the right to request certification of creditable coverage from the carrier or administrator of your prior coverage. Other types of coverage besides a group health

plan may qualify as prior creditable coverage.

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 can not 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 do and will be allowed to enroll immediately. You or your spouse's employer or group sponsor will withhold any applicable share of the dependent's health care premiums from your compensation and forward this amount to us.

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

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

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

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

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

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

9. Coverage Changes and Termination

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

Coverage Change Events

Coverage Enrollment Events: The following events allow you as well as an affected spouse, domestic partner, or eligible child to enroll for coverage. If your employer or group sponsor offers more than one group health plan, the event also allows you to move from one plan option to another.

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

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

- Dependent child resumes status as a full-time student.
- Addition of a natural child by court order. See *Qualified Medical Child Support Order*, page 41.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

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

- Death.

- Divorce or annulment.
- Medicare eligibility. If you become eligible for Medicare, you must notify your employer or group sponsor immediately. If you are eligible for this group health plan other than as a current employee or a current employee's spouse, your Medicare eligibility may terminate this coverage.

In case of the following coverage removal events, the affected dependent child's coverage may be continued until the next group coverage renewal date on or after the date of the event:

- Completion of a dependent's full-time schooling if the dependent is age 25 or older.
- Dependent child who is not a full-time student or permanently disabled reaches age 25.
- Marriage of a dependent child.

Please note: If a coverage removal event during the benefit year changes your coverage type from family to single coverage, you will not be credited with deductible and out-of-pocket maximum amounts that were paid during the benefit year on behalf of the removed family member. See *Payment Details*, page 3.

Requirement to Notify Group Sponsor

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

- A birth, adoption, or placement for adoption.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).

- You become eligible for premium assistance under Medicaid or CHIP.

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

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

If you do not provide timely notification of a coverage enrollment event, the person affected by a coverage enrollment event is subject to the 18-month preexisting condition exclusion period for late enrollees. See *Preexisting Condition Exclusion Period*, page 39.

Coverage Termination

The following events terminate your coverage eligibility.

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

Also see *Fraud, Misrepresentation, Concealment of Material Facts, or 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 are an inpatient of a hospital or a resident of a nursing facility on the date your coverage eligibility terminates, benefits for inpatient services are limited to the least amount of the following:

- The period of your remaining days of coverage under this medical benefits plan.
- The period ending on the date you are discharged from the facility.
- A period not more than 60 days from the date of termination.

Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or fraudulently misrepresent or conceal 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.
- You or your employer or group sponsor fails to make required payments to us when due, or you fail to pay any applicable amounts you owe.

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

- We may declare this group health plan void.
- Premiums will be retroactively adjusted as if a misrepresented or concealed material fact had been accurately disclosed in your application.
- We will recover any claim payments made, minus any premiums paid.
- We will retain legal rights, including the right to bring a civil action.

Certificate of Creditable Coverage

Wellmark will provide certification of your coverage under this medical benefits plan if:

- This coverage terminates.
- You become eligible for COBRA coverage or coverage continuation under Iowa law.
- You exhaust your COBRA coverage.
- You request certification of your coverage within 24 months after this coverage terminates. See *Notice*, page 62.

Coverage Continuation

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

COBRA Continuation

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

Continuation for Public Group

Iowa Code Sections 509A.7 and 509A.13 may apply if you are an employee of the State, an Iowa school district, or other public entity supported by public funds. If this law applies to you, you may be entitled to continue participation in this medical benefits plan when you retire. You are responsible for paying any premiums to your employer.

Group Conversion Coverage

If your eligibility under this group coverage ends or if a family member becomes ineligible for coverage, you or the family member may be eligible for a conversion policy or a Blue Transitions policy.

If you apply for group conversion coverage within 31 days or Blue Transitions coverage within 60 days of the date your employment ends or of the event making a family member ineligible for coverage, you may be eligible under a group conversion policy or Blue Transitions policy without medical underwriting.

The benefits provided by the conversion policy or Blue Transitions policy may not be identical to the coverage provided under your group medical benefits plan and will be subject to different premium rates. For information about available benefits, eligibility criteria, and premium rates for conversion coverage or Blue Transitions coverage, contact us. We will provide you with a copy of a conversion policy upon your request.

You are not eligible for a group conversion policy if you are eligible for or enrolled in Medicare.

Continuation Under Iowa Law

Under Iowa Code Chapter 509B, you may be eligible to continue your medical care coverage for up to nine months if:

- You lose the coverage you have been receiving through your employer or group sponsor; and
- You have been covered by your medical benefits plan continuously for the last three months.

Your employer or group sponsor must provide written notice of your right to continue coverage within 10 days of the last day you are considered employed or your coverage ends. You will then have 10 days to give your employer or group sponsor written notice that you want to continue coverage.

Your right to continue coverage ends 31 days after the date of your employment termination or the date you were given notice of your continuation right, whichever is later.

If you lose your coverage because of divorce, annulment, or death of the employee, you must notify the employer or group sponsor providing the coverage within 31 days.

Benefits provided by continuation coverage may not be identical to the benefits that active employees have and will be subject to different premium rates. You will be responsible for paying any premiums to your employer or group sponsor for continuation coverage.

If you believe the Iowa continuation law applies to you, you may contact your employer or group sponsor for information on premiums and any necessary paperwork.

If you are eligible for coverage continuation under both Iowa law and COBRA, your employer can comply with Iowa law by offering only COBRA continuation.

10. Claims

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

When to File a Claim

You need to file a claim if you:

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

Wellmark must receive claims within 365 days following the date of service of the claim.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

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

2. Fill Out the Claim Form

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

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

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

- Use a separate claim form for each covered family member and each provider.
- Attach a copy of an itemized statement prepared by your provider. We cannot

accept statements you prepare, cash register receipts, receipt of payment notices, or balance due notices. In order for a claim request to qualify for processing, the itemized statement must be on the provider's stationery, and include at least the following:

- Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
- Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.
- Date(s) of service.
- Charge for each service.
- Place of service (office, hospital, etc).
- For injury or illness: date and diagnosis.
- For inpatient claims: admission date, patient status, attending physician ID.
- Days or units of service.
- Revenue, diagnosis, and procedure codes.
- Description of each service.

Prescription Drugs Claim Form. For prescription drugs covered under your medical benefits plan, use a separate prescription drug claim form and include the following information:

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

3. Sign the Claim Form

4. Submit the Claim

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

Medical Claims. Send the claim to:

Wellmark Blue Cross and Blue Shield of
Iowa
636 Grand Avenue, Station 39
Des Moines, IA 50309-2565

Prescription Drug Claims. Send the claim to:

Catalyst Rx
Claims Department
P.O. Box 1069
Rockville, MD 20849-1069

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

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017

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

Notification of Decision

We will send an Explanation of Health Care 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 49.

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. In the case of nonparticipating hospitals, M.D.'s, and D.O.'s located in Iowa, the health plan payment is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider, plus any difference between the amount charged and our payment.

11. Coordination of Benefits

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

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

Other Coverage

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

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

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

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.

- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for non-medical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

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

Your participating or PPO provider will forward your coverage information to us. If you have a nonparticipating provider, you are responsible for informing us about your other coverage.

Claim Filing

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

Rules of Coordination

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

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide out-of-network benefits.)
- The 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 is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Dependent Children

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

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
 - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility

has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

- If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

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

Effects on the Benefits of this Plan

When this plan is secondary, we may reduce its benefits so that total benefits paid or provided by all plans during a plan year are

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

Right of Recovery

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

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations. The following provisions apply only if you have both Medicare and employer group health coverage under this medical benefits plan and your employer has the required minimum number of employees.

Working Aged

If you are a member of a group health plan of an employer with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year, then 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

If you are a member of a group health plan of an employer with at least 100 full-time, part-time, or leased employees on at least 50 percent of regular business days during the preceding calendar year, then 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)

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

- The beneficiary has Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer group health plan.

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

This is only a general summary of the laws, which may change from time to time. For more information, contact your employer or the Social Security Administration.

12. Appeals

Right of Appeal

You have the right to one full and fair review in case of a denied or reduced claim, or an adverse decision concerning a pre-service notification requirement. An adverse decision is one that denies or reduces benefits. Pre-service notification requirements are:

- Continued stay in a facility.
- A precertification request.
- A prior approval request.
- A prior authorization request for prescription drugs.

How to Appeal

You or your authorized representative, if you have designated one, may appeal a reduced or denied benefit by calling the Customer Service number on your ID card or by writing to Wellmark. See *Authorized Representative*, page 57.

Medically Urgent Appeal

For appeals involving a medically urgent situation, you may request an expedited appeal, either orally or in writing.

Non-Medically Urgent Appeal

For appeals that are not medically urgent, you must make your request for a review, in writing, within 180 days from the date you are notified of our adverse decision.

What to Include in Your Appeal

You must submit all relevant information with your initial 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 Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Appeals/ERISA Review Office
636 Grand Avenue, Station 52
Des Moines, IA 50309-2565

Review of Appeal

Your request for an appeal will be reviewed only once. The review will take into account all information regarding the adverse decision 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 decision.

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. 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 Appeal

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

Medically Urgent Appeal

For a medically urgent appeal, you will be notified (by telephone, email, fax or another prompt method) of our decision as soon as possible, but no later than 72 hours after your expedited appeal is received. Written notification will follow within three days of the initial notice.

Non-Medically Urgent Appeal

An appeal of a denied or reduced claim will be decided within 60 days. An appeal of an adverse decision concerning a pre-service notification requirement will be decided within 30 days.

Legal Action

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

External Review Process

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider, if you have authorized your provider to act on your behalf, may request an external review of our decision through the Iowa Commissioner of Insurance.

If you authorize your provider to act on your behalf, this authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. See *Authorized Representative*, page 57.

Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

13. Your Rights Under ERISA

Employee Retirement Income Security Act of 1974

Your rights concerning your coverage may be protected by the Employee Retirement Income Security Act of 1974 (ERISA), a federal law protecting your rights under this benefits plan. Any employee benefits plan established or maintained by an employer or employee organization or both is subject to this federal law unless the benefits plan is a governmental or church plan as defined in ERISA.

As a participant in this group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

You may examine, without charge, at the plan administrator's office or at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

You may also obtain a summary of the plan's annual financial report. The plan administrator is required by law to furnish you with a copy of this summary annual report.

Continued Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. For more information on the rules governing your COBRA continuation coverage rights, review this coverage manual and the documents governing the plan. See *COBRA Continuation*, page 45.

You have the right to reduced or eliminated exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

- You lose coverage under the plan.
- You become entitled to COBRA continuation coverage.
- Your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion period for up to 12 months (up to 18 months for late enrollees) after your enrollment date in the coverage. See *Certificate of Creditable Coverage*, page 45.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of your employee benefits plan. The people who operate the plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one,

including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Rights

If your claim for a covered benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you

need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor*, listed in the telephone directory, or write to:

Division of Technical Assistance and
Inquiries
Employee Benefits Security
Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the *Employee Benefits Security Administration*.

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 coverage manual 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 Coverage Manual

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

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

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage

manual at any time. Any amendment or modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

Authorized Group Health Plan Changes

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

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor as shown by payment of the premium.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 43.

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 www.wellmark.com or by calling the Customer Service number on your ID card.

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

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

representative at a time. You may revoke the authorized representative at any time.

Release of Information

You have agreed in your application (or in documents kept by us or your employer or group sponsor) to release any necessary information requested about you so we can process claims for benefits.

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

Privacy of Information

We are committed to protecting the privacy of your health information. We will request, use, or disclose your health information only as permitted or required by law.

Wellmark has issued a *Privacy Practices Notice*. This notice is available upon request or at www.wellmark.com.

We 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 premiums, 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, rating our risk and determining premiums 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

We will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person.

Member Health Support Services

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

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health

support service vendors, for purposes of providing such services to you.

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

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions.

Nonassignment

Benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. You are prohibited from assigning any claim or cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan or rights to payment will be void.

Governing Law

To the extent not superseded by the laws of the United States, the group health plan will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.

Legal Action

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

You shall not bring any legal or equitable action against us because of a claim under this group health plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in

which the services or supplies were provided.

Medicaid Enrollment

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.

Subrogation

Right of Subrogation

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

Right of Reimbursement

If you are injured as a result of the act of a third party and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse Wellmark for all benefits paid for the injury from money received

from the third party or its insurer, to the extent of the amount paid by Wellmark on the claim.

Once you receive benefits under this group health plan arising from an illness or injury, Wellmark will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any of the following:

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

You agree to recognize Wellmark's rights to subrogation and reimbursement. These rights provide Wellmark with a priority over any money paid by a third party to you relative to the amount paid by Wellmark, including priority over any claim for non-medical charges, or other costs and expenses. Wellmark will assume all rights of recovery, to the extent of payment, 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 Wellmark requests with respect to the exercise of Wellmark's 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 Wellmark in writing if you were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such injury to Wellmark as a condition to receipt of benefits:

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

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue, Station 151
Des Moines, IA 50309-2565

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 by Wellmark in connection with the illness or injury) in trust for the benefit of Wellmark as trustee(s) for Wellmark until the extent of our right to reimbursement or subrogation has been resolved.

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

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.

Wellmark's right of subrogation and reimbursement under this group health plan applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and

reimbursement if there is any recovery on your claim.

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

Workers' Compensation

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

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

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

Payment in Error

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

Premium

Your employer or group sponsor must pay us in advance of the due date assigned for your coverage. For example, payment must be made prior to the beginning of each

calendar month, each quarter, or each year, depending on your specific due date.

If you misrepresent any information to Wellmark relating to this coverage, Wellmark may, in addition to exercising any other available remedies, retroactively adjust the monthly premiums for this coverage as if the information in question had been correctly represented in the application for coverage.

Notice

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

Wellmark Blue Cross and Blue Shield of
Iowa
636 Grand Avenue
Des Moines, IA 50309-2565

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

Glossary

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

Accidental Injury. An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

Admission. Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

Amount Charged. The amount that a provider bills for a service or supply, whether or not it is covered under this group health plan.

Benefit Year. A calendar year, starting over each January 1. A benefit year continues even if you change coverage under group health plans sponsored by your employer or group sponsor and administered by Wellmark.

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

BlueCard Program. The Blue Cross and Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of PPO Network providers throughout the United States.

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

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed

services, and for their dependents (Chapter 55 of Title 10, United States Code).

- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

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

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

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

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

Medically Urgent Situation. A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would

subject the member to severe pain that cannot be managed without the services in question.

Medicare. The federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member. A person covered under this group health plan.

Nonparticipating Provider. A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan.

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

Participating Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield Plan but not with a preferred provider program.

Plan. The group health benefits program offered to you as an eligible employee for purposes of ERISA.

Plan Administrator. The employer or group sponsor of this group health plan for purposes of the Employee Retirement Income Security Act.

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

PPO Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield preferred provider program.

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

Spouse. A husband or wife as the result of a marriage that is legally recognized in Iowa, including common law.

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

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

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

Index

A

accident deductible	3
accidental injury.....	12
acupressure	11
acupuncture	7, 11
acute rehabilitation facilities	29
addiction	7, 11
admissions	29, 31
adoption	39, 40, 43
advanced registered nurse practitioners	8, 19
allergy services	7, 11
ambulance services	7, 11
ambulatory facility	15
ambulatory facility services	12
amount charged	37
anesthesia.....	7, 11, 12
annulment.....	43
appeals	29, 53
assignment of benefits	59
athletic trainers	19
audiologists	8, 19
authority to terminate or amend.....	57
authorized representative	57

B

benefit coordination.....	49
benefit year.....	35
benefit year deductible.....	3
benefits maximum	4
bereavement counseling	12
biological products.....	19
blood.....	7, 11
BlueCard program	28, 35
bone marrow transplants.....	21
braces	14, 17, 20
brain injuries.....	32
breast reconstruction	21

C

care coordination	29
case management.....	31
changes of coverage	43

chemical dependency	7, 11
chemical dependency treatment facility	15
chemotherapy	7, 11
child support order	41
children	39, 40, 41, 43, 50
chiropractic services	8, 18
chiropractors.....	8, 19
claim filing	47, 49
claim forms	47
claim payment	48
COBRA coverage.....	43, 45
coinsurance.....	3, 4, 35
common accident deductible	3
communication disorders.....	17
community mental health center	15
complications.....	25
concealment of material fact	44
conditions of coverage	23
continued stay review	31
contraceptives.....	19
contract	57
contract amendment	57
contract interpretation	57, 59
convenience items	25
conversion coverage	45
coordination of benefits.....	49
coordination of care.....	29
cosmetic services	7, 11
cosmetic surgery	9, 21
counseling	7, 12
coverage changes	43, 57
coverage continuation	45
coverage effective date.....	39
coverage eligibility	39, 43
coverage termination.....	44
creditable coverage	40, 43, 45
custodial care	14
cystic fibrosis	32

D

death	43
deductible	3

deductible amounts 3
 degenerative muscle disorders 32
 dental services 7, 12
 dependents 39, 40, 41, 43, 50
 diabetes 8, 12
 diabetic education 8, 12
 dialysis 7, 12
 dietary products 18
 disabled dependents 39
 divorce 43
 doctors 8, 9, 19
 doctors of osteopathy 8, 19
 drug abuse 7, 11
 drug prior authorization 32
 drug rebates 38
 drugs 9, 19, 37

E

effective date 39
 eligibility for coverage 39, 43
 emergency services 8, 13
 employment physicals 20
 EOB (explanation of health care benefits) 48
 ERISA 55
 exclusion period 39, 40, 44
 exclusions 23, 24
 experimental services 24
 explanation of health care benefits (EOB) 48
 external review 54
 eye services 9, 22
 eyeglasses 22

F

facilities 8, 15
 family counseling 12
 family deductible 3
 family member as provider 25
 fertility services 8, 13, 30
 filing claims 47, 49
 foot care (routine) 20
 foot doctors 9, 19
 foreign countries 19, 28
 foster children 39, 43
 fraud 44

G

gamete intrafallopian transfer 13
 genetic testing 8, 13, 30
 GIFT (gamete intrafallopian transfer) 13
 government programs 25, 49
 group conversion coverage 45
 gynecological examinations 9, 20

H

hair pieces 9, 22
 hearing services 8, 13
 hemophilia 32
 high risk pregnancy 32
 home health services 8, 14, 29, 31, 32
 home infusion therapy 20, 29, 31
 home office (Wellmark) 62
 home skilled nursing 14
 home/durable medical equipment 8, 14, 15, 30
 hospice respite care 15
 hospice services 8, 15, 29, 31
 hospital services 12, 44
 hospitals 8, 15

I

ID card 27, 28
 illness 8, 16
 immunizations 20
 impacted teeth 12
 in vitro fertilization 13
 infertility treatment 8, 13, 30
 information disclosure 58
 inhalation therapy 8, 14, 16
 injectable drugs 20
 injury 8, 16
 inpatient facility admission 29, 31
 inpatient services 35, 44
 insulin 20
 insulin supplies 16
 investigational services 24

K

kidney dialysis 12

L

L.P.N. 14
 laboratory services 9, 22

late enrollees40, 44
 legal action 59
 licensed independent social workers..... 9, 19
 licensed practical nurses 14
 lifetime benefits maximum 4, 25
 limitations of coverage..... 4, 7, 23, 25
 lodging..... 9, 22

M

mammograms9, 20
 marriage43
 marriage counseling..... 12
 massage therapy..... 18
 mastectomy 21
 maternity services 8, 16
 maximum allowable fee 37
 medicaid enrollment..... 59
 medical doctors 8, 9, 19
 medical equipment8, 14, 15
 medical supplies..... 8, 16
 medical support order 41
 medically necessary 23
 Medicare.....43, 49
 medicines9, 19, 37
 mental health services 8, 17
 mental health treatment facility 15
 mental illness 8, 17
 military service.....25
 misrepresentation.....44
 morbid obesity treatment 8, 17
 motor vehicles 8, 18
 muscle disorders32
 musculoskeletal treatment 8, 18

N

network savings 37
 newborn children40, 43
 nicotine dependence 17, 20
 nonassignment of benefits..... 59
 nonmedical services 8, 18, 25
 nonparticipating providers36
 notice..... 62
 notification of change 43
 notification requirements29
 nursing facilities..... 15, 29, 44

nutritional products18

O

obesity surgery..... 30
 obesity treatment.....8, 17
 occupational therapists9, 19
 occupational therapy 8, 14, 18
 optometrists.....9, 19
 oral contraceptives19
 oral surgeons9, 19
 organ transplants.....9, 21
 orthotics..... 8, 18
 osteopathic doctors.....8, 19
 other insurance..... 25, 49
 out of state facilities..... 29
 out-of-area coverage19, 28, 35
 out-of-pocket maximum..... 3, 4
 over-the-counter products 8, 18
 oxygen 14, 16

P

pap smears 20
 participating providers 27
 payment arrangements..... 37
 payment in error.....61
 payment obligations 3, 4, 23, 26, 30, 35
 personal items 25
 physical examinations 9, 20
 physical therapists9, 19
 physical therapy..... 8, 14, 18
 physician assistants9, 19
 physicians8, 9, 19
 plastic surgery..... 7, 11
 podiatrists9, 19
 PPO providers..... 27, 36
 practitioners.....8, 19
 precertification15, 26, 29
 preexisting conditions 39, 44
 preferred provider organization (PPO)..... 27
 pregnancy16
 pregnancy (high risk) 32
 premiums.....61
 prenatal services16
 prescription drugs 9, 19, 37
 preventive care..... 9, 20

prior approval30
 prior authorization.....26, 32
 prior creditable coverage40
 privacy58
 pronuclear stage transfer (PROST) 13
 prosthetic appliances 9, 14, 20
 psychiatric services17
 psychologists 9, 19
 public employees..... 45

Q

qualified medical child support order 41

R

R.N. 8, 14, 16, 19
 radiation therapy 7, 11
 rebates38
 reconstructive surgery 9, 21, 30
 registered nurses..... 8, 14, 16, 19
 reimbursement of benefits..... 59, 61
 release of information58
 removal from coverage 43
 residential treatment 11, 17
 residential treatment facility 16
 respiratory therapy8, 14, 16
 rights of action59
 rights of appeal..... 53
 routine services9, 20

S

self-administered injections20
 self-help..... 9, 21
 service area.....28
 service maximums 7
 sexual identification disorders17
 skilled nursing services 14
 sleep apnea..... 9, 21, 30
 social workers..... 9, 19
 speech pathologists 9, 19
 speech therapy 9, 21, 30

spinal cord injuries 32
 sports physicals..... 20
 spouses..... 39, 43
 stepchildren 39
 sterilization13
 students..... 39, 43
 subrogation 59
 surgery9, 21
 surgical facility.....15
 surgical facility services12
 surgical supplies8, 16

T

temporomandibular joint disorder9, 21
 termination of coverage..... 44
 third party liability..... 25
 TMD (temporomandibular joint disorder) ...9, 21
 tooth removal.....12
 transplants 9, 21, 30, 32
 travel 9, 22
 travel physicals 20
 tubal ligation13

V

vaccines8, 14, 16
 vasectomy13
 vehicles..... 8, 18
 vision services 9, 22

W

weight reduction8, 17, 30
 well-child care..... 9, 20
 Wellmark drug list 37
 wigs 9, 22
 workers' compensation.....25, 61

X

x-rays 9, 22

