S U M M A R Y P L A N
D E S C R I P T I O N

North Scott Community School District
Group Medical Plan

Group Effective Date: 4/1/2025
Plan Year: April 1
Product ID: PL001653

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

AllianceSelect℠
North Scott CSD PPO

NOTICE

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

Group Effective Date: 4/1/2025
Plan Year: April 1
Print Date: 5/2/2025
Product ID: PL001653
Version: 01/25

Form Number: Wellmark IA Grp North Scott CSD AS – Version: 01/23
Form Number: Wellmark IA Grp

Contents

About This Summary Plan Description 1

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

2. At a Glance - Covered and Not Covered 9

3. Details - Covered and Not Covered 13

4. General Conditions of Coverage, Exclusions, and Limitations 31
Conditions of Coverage 31
General Exclusions 32
Benefit Limitations 34

5. Choosing a Provider 37

6. Notification Requirements and Care Coordination 45

7. Factors Affecting What You Pay 51

8. Coverage Eligibility and Effective Date 57
Eligible Members 57
Eligibility Requirements 57
When Coverage Begins 58
Late Enrollees 58
Changes to Information Related to You or to Your Benefits 58
Qualified Medical Child Support Order 58
Family and Medical Leave Act of 1993 59

9. Coverage Changes and Termination 61
Coverage Change Events 61
Requirement to Notify Group Sponsor 62
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) 62
Coverage Termination 64
Coverage Continuation 65

10. Claims 75
When to File a Claim 75
How to File a Claim 75
Notification of Decision 76

11. Coordination of Benefits 79
Other Coverage 79
Claim Filing 79
Rules of Coordination 79
Coordination with Medicare 82

12. Appeals 85
Right of Appeal 85
How to Request an Internal Appeal 85
Where to Send Internal Appeal 85
Review of Internal Appeal 85
Decision on Internal Appeal 86
External Review 86

Arbitration and Legal Action 87

13. Arbitration and Legal Action 89

Mandatory Arbitration 89
Covered Claims 89
No Class Arbitrations and Class Actions Waiver 89
Claims Excluded from Mandatory Arbitration 89
Arbitration Process Generally 90
Arbitration Fees and Other Costs 91
Confidentiality 91
Questions of Arbitrability 91
Claims Excluded By Applicable Law 91
Survival and Severability of Terms 91

14. General Provisions 93

Contract 93
Interpreting this Summary Plan Description 93
Plan Year 93
Authority to Terminate, Amend, or Modify 93
Authorized Group Benefits Plan Changes 93
Authorized Representative 93
Release of Information 94
Privacy of Information 94
Member Health Support Services 95
Value Added or Innovative Benefits 95
Value-Based Programs 95
Nonassignment 95
Governing Law 95
Medicaid Enrollment and Payments to Medicaid 96
Subrogation 96
Workers' Compensation 98
Payment in Error 99
Notice 99
Submitting a Complaint 99
Consent to Telephone Calls and Text or Email Notifications 99

Glossary 101

Index 105

About This Summary Plan Description

Important Information

This summary plan description describes your rights and responsibilities under your group health plan. You and your covered dependents have the right to request a copy of this summary plan description, 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 summary plan description at any time. Any amendment or modification will be in writing and will be as binding as this summary plan description. If your contract is terminated, you may not receive benefits.

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

This summary plan description contains a summary in English of your plan rights and benefits under North Scott Community School District Group Medical Plan. If you have difficulty understanding any part of this summary plan description, contact your employer or group sponsor.

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 summary plan description. (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 summary plan description. For instance, most information on coverage will be found in these sections:

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

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

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

Read Thoroughly

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

Your coverage includes many services, treatments, supplies, devices, and drugs. Throughout the summary plan description, 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.

Plan Description

Plan Name:	North Scott Community School District Group Medical Plan
Plan Sponsor:	North Scott Community School District
Employer ID Number:	42-6023564
When Plan Year Ends:	March 31
Participants of Plan:	Eligible employees and their dependents See *Coverage Eligibility and Effective Date* later in this summary plan description.
Plan Administrator and Agent for Service of Legal Process:	North Scott Community School District Attn: Jill Van Roekel 251 E. Iowa Street Eldridge, IA 52748 Phone Number: 563-285-4147 Service of legal process may be made upon the plan administrator and/or agent.
How Plan Costs Are Funded:	Employer and employee contributions
Type of Plan:	Group Health Plan
Type of Administration:	Self-Funded
Benefits Administered by:	Wellmark Blue Cross and Blue Shield of Iowa 1331 Grand Avenue Des Moines, IA 50309-2901

If this plan is maintained by two or more employers, you may write to the plan administrator for a complete list of the plan sponsors.

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 summary plan description, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

In-Network Providers

PPO Providers. These providers participate with the Wellmark Blue PPO℠ network or with a Blue Cross and/or Blue Shield PPO network in another state or service area. You typically pay the least for services received from these providers. Throughout this summary plan description we refer to these providers as PPO Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO network. You typically pay more for services from these providers than for services from PPO Providers. Throughout this summary plan description we refer to these providers as Participating Providers.

Out-of-Network Providers

Out-of-Network Providers. Out-of-Network Providers do not participate with Wellmark or any other Blue Cross and/or Blue Shield Plan. You typically pay the most for services from these providers. Throughout this summary plan description we refer to these providers as Out-of-Network Providers.

Payment Summary

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

You Pay
Deductible
$1,200 per person for covered services received from PPO Providers. **$2,375** (maximum) per family* for covered services received from PPO Providers. **$1,375** per person for covered services received from Participating and Out-of-Network providers. **$2,750** (maximum) per family* for covered services received from Participating and Out-of-Network providers.
Coinsurance
15% for covered services received from PPO Providers. **20%** for covered services received from Participating and Out-of-Network providers.

You Pay
Out-of-Pocket Maximum
$2,875 per person for covered services received from PPO and Participating providers. **$5,750** (maximum) per family* for covered services received from PPO and Participating providers. **$3,000** per person for covered services received from Out-of-Network Providers. **$6,000** (maximum) per family* for covered services received from Out-of-Network Providers.

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

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 covered family members.

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

Deductible amounts you pay for PPO or Participating and Out-of-Network provider services apply toward meeting both the PPO and the Participating/Out-of-Network deductibles. The maximum deductible amount you pay is the Participating/Out-of-Network deductible.

Once you meet the deductible, then coinsurance applies.

When the No Surprises Act applies, you may not be required to satisfy your entire deductible before we make benefit payments, amounts you pay for items and services will accumulate toward your PPO deductible, and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act applies to emergency services at an Out-of-Network facility, items and services from Out-of-Network Providers related to visits to certain participating facilities, and Out-of-Network air ambulance services.

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 51. Coinsurance amounts apply after you meet the deductible.

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

Out-of-Pocket Maximum

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

- Deductible.
- Coinsurance.

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

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

There is an out-of-pocket maximum for services you receive from PPO Providers and Participating Providers. There is also an out-of-pocket maximum for services you receive from Out-of-Network Providers. These out-of-pocket maximums accumulate to one another.

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 31.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.

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

When the No Surprises Act applies, amounts you pay for items and services will accumulate toward your PPO out-of-pocket maximum and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act applies to emergency services at an Out-of-Network facility, items and services from Out-of-Network Providers related to visits to certain participating facilities, and Out-of-Network air ambulance services.

Benefits Maximums

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

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

No Surprises Act

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

Waived Payment Obligations

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

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Breast pumps (manual or non-hospital grade electric)§ purchased from a covered PPO or Participating home/durable medical equipment provider.	Deductible Coinsurance

Covered Service	Payment Obligation Waived
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding§ when received from PPO or Participating providers.	Deductible Coinsurance
Contraceptive medical devices, such as intrauterine devices and diaphragms§ received from PPO or Participating providers.	Deductible Coinsurance
Implanted and injected contraceptives§ received from PPO or Participating providers.	Deductible Coinsurance
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines§ when received from PPO or Participating providers.	Deductible Coinsurance
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services.	Deductible
Postpartum home visit (one).**	Deductible Coinsurance
Preventive care, items, and services,* § received from PPO or Participating providers, as follows: ■ Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP); ■ Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and ■ Preventive care and screenings for women provided for in guidelines supported by the HRSA.	Deductible Coinsurance
Preventive digital breast tomosynthesis (3D mammogram) when received from PPO or Participating providers.	Deductible Coinsurance
Prosthetic limb devices received from PPO Providers.	Deductible
Telehealth services received from practitioners contracting through Doctor on Demand.‡	Deductible Coinsurance
Voluntary sterilization for female members§ received from PPO or Participating providers.	Deductible Coinsurance
Well-child care.	Deductible

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

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

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

§When preventive care is received from Out-of-Network Providers, only coinsurance is waived.

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 summary plan description. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 13. To fully understand which services are covered and which are not, you must become familiar with this entire summary plan description. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

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

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

Not Covered. The listed category is generally not covered.

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

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

Category	Covered	Not Covered	See Page	Benefits Maximums
Acupuncture Treatment		⊘	13	
Allergy Testing and Treatment	●		13	
Ambulance Services	●		13	
Anesthesia	●		14	
Applied Behavior Analysis (ABA) Services	●		14	
Autism Spectrum Disorder Treatment	●		14	
Blood and Blood Administration	●		14	
Chemical Dependency Treatment	●		14	
Chemotherapy and Radiation Therapy	●		15	
Clinical Trials – Routine Care Associated with Clinical Trials	●		15	
Contraceptives	●		15	
Conversion Therapy		⊘	15	

Category	Covered	Not Covered	See Page	Benefits Maximums
Cosmetic Services		⊘	15	
Counseling and Education Services	●		16	
Dental Treatment for Accidental Injury	●		16	
Dialysis	●		17	
Education Services for Diabetes	●		17	
Emergency Services	●		17	
Fertility Services	●		17	
Genetic Testing	●		18	
Hearing Services	●		18	One routine hearing examination per benefit year.
Home Health Services	●		18	The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		19	
Hospice Services	●		19	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	●		20	
Illness or Injury Services	●		20	
Infertility Treatment		⊘	21	
Inhalation Therapy	●		21	
Maternity Services	●		21	
Medical and Surgical Supplies and Personal Convenience Items	●		22	
Mental Health Services	●		22	
Motor Vehicles		⊘	23	
Musculoskeletal Treatment	●		23	
Nonmedical or Administrative Services		⊘	24	
Nutritional and Dietary Supplements	●		24	
Nutritional Counseling	●		24	
Occupational Therapy	●		24	
Orthotics (Foot)	●		25	

Category	Covered	Not Covered	See Page	Benefits Maximums
Physical Therapy	●		25	
Physicians and Practitioners			25	
Advanced Registered Nurse Practitioners	●		25	
Audiologists	●		25	
Chiropractors	●		25	
Doctors of Osteopathy	●		25	
Licensed Independent Social Workers	●		25	
Licensed Marriage and Family Therapists	●		25	
Licensed Mental Health Counselors	●		25	
Medical Doctors	●		25	
Occupational Therapists	●		25	
Optometrists	●		25	
Oral Surgeons	●		25	
Physical Therapists	●		25	
Physician Assistants	●		25	
Podiatrists	●		25	
Psychologists	●		25	
Speech Pathologists	●		25	
Prescription Drugs	●		26	
Preventive Care	●		26	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year.
Prosthetic Devices	●		27	
Reconstructive Surgery	●		27	
Self-Help Programs		⦸	27	
Sleep Apnea Treatment	●		28	
Social Adjustment		⦸	28	
Speech Therapy	●		28	
Surgery	●		28	
Telehealth Services	●		28	
Temporomandibular Joint Disorder (TMD)	●		28	
Transplants	●		28	
Travel or Lodging Costs	●		29	$10,000 per transplant; $200 per day for lodging and transportation.

Category	Covered	Not Covered	See Page	Benefits Maximums
Vision Services (related to an illness or injury)	●		29	
Wigs or Hairpieces	●		29	$300 per lifetime.
X-ray and Laboratory Services	●		29	

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 summary plan description. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 31. 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:

- Emergency air and ground ambulance transportation to a hospital.

  All of the following are required to qualify for benefits:

  - If you are inpatient, the services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital with adequate facilities to treat your medical condition.
  - During transport, your medical condition requires the services that are provided only by an air or ground ambulance.
  - Your medical condition requires immediate ambulance transport.
  - In addition to the preceding requirements, for emergency air ambulance services to be covered, the following must be met:
    - Great distances, inaccessibility of the pickup location by a land vehicle, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment by ground transport.

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

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

- Non-emergency air or ground ambulance transportation to a hospital or nursing facility.

  All of the following are required to qualify for benefits:

  - The services required to treat your illness or injury are not available where you are currently receiving care.
  - You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.
  - During transport your medical condition requires the services that are provided only by an air or ground ambulance.

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

Not Covered:

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

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Applied Behavior Analysis (ABA) Services

Covered: Applied Behavior Analysis services when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist or a licensed behavior analyst.

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder.

Blood and Blood Administration

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

Chemical Dependency Treatment

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

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

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;

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

Not Covered:

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

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 45.

Chemotherapy and Radiation Therapy

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

Clinical Trials – Routine Care Associated with Clinical Trials

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

Not Covered:

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

Contraceptives

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

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

Not Covered:

- Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.

Conversion Therapy

Not Covered: Conversion therapy services.

Cosmetic Services

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

See Also:

Reconstructive Surgery later in this section.

Counseling and Education Services

Covered:

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

Not Covered:

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

See Also:

Genetic Testing later in this section.

Education Services for Diabetes later in this section.

Mental Health Services later in this section.

Nutritional Counseling later in this section.

Preventive Care later in this section.

Dental Services

Covered:

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

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

Not Covered:

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

Dialysis

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

Education Services for Diabetes

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

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

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

Emergency Services

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

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

In an emergency situation, if you cannot reasonably reach a PPO Provider, covered services will be reimbursed as though they were received from a PPO Provider, unless the No Surprises Act applies. When the No Surprises Act applies to emergency services, claims will be processed in accordance with the Act and you cannot be billed for the difference between the amount charged and the total amount paid by us. If you receive medically necessary emergency services to treat an emergency medical condition, those services will be covered as required under the No Surprises Act notwithstanding any other plan exclusion.

See Also:

Out-of-Network Providers, page 53.

Fertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

Not Covered:

- Services and supplies associated with an abortion that is elective. Abortions performed when the life of the mother would be at risk if the pregnancy were to go to full term are an exception and therefore a covered benefit. Services performed to treat complications

resulting from a noncovered abortion are a covered benefit.

Genetic Testing

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

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

Hearing Services

Covered:

- Hearing examinations to test or treat hearing loss related to an illness or injury.
- Routine hearing examinations.

Benefits Maximum:

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

Not Covered:

- Hearing aids.

Home Health Services

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

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

The following are covered services and supplies:

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

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

— is provided for a definite limited period of time as a safe transition from other levels of care when medically necessary;

— provides teaching to caregivers for ongoing care; or

— provides short-term treatments that can be safely administered in the home setting.

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

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered:

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

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

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

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

See Also:

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

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Hospice Services

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

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

Benefits Maximum:

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

Hospitals and Facilities

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

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

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

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

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

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

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

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

Not Covered:

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

Please note:

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

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illness or Injury Services

Covered:

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this

section. This includes pregnancy and complications of pregnancy.

- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.
- Fertility preservation services for medical treatment likely to cause irreversible infertility, such as chemotherapy, surgery, and radiation treatment. This includes ovarian stimulation, retrieval of eggs, and collection of sperm.

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

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

Not Covered:

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

Infertility Treatment

Not Covered:

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

Inhalation Therapy

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

Maternity Services

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

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

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

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

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

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

If you have a newborn child, but you do not add that child to your coverage, your newborn child may be added to your coverage solely for the purpose of administering benefits for the newborn during the first 48 hours following a vaginal delivery or 96 hours following a cesarean

delivery. If that occurs, a separate deductible and coinsurance may be applied to your newborn child unless your coverage specifically waives the deductible or coinsurance for your newborn child. If the newborn is added to or covered by and receives benefits under another plan, benefits will not be provided under this plan.

See Also:

Coverage Change Events, page 61.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

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

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

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

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Mental Health Services

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

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

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

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

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

Not Covered:

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

See Also:

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

Motor Vehicles

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

Musculoskeletal Treatment

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

Not Covered:

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

Nonmedical or Administrative Services

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

Nutritional and Dietary Supplements

Covered:

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

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

- Food products.
- Grocery items or food products that are modified for special diets for individuals with inborn errors of metabolism but which can be purchased without a prescription issued by or authorized by a licensed healthcare practitioner, including low protein/low phe grocery items.
- Herbal products.
- Fish oil products.
- Medical foods, except as described under *Covered*.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

Nutritional Counseling

Covered: You may be covered for medically necessary nutritional counseling for the management of chronic illnesses or conditions in which dietary adjustment has a therapeutic role.

Not Covered: Nutritional counseling for conditions that have not shown to be nutritionally related or there is no therapeutic role of nutritional interventions.

Occupational Therapy

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

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

Not Covered:

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

Orthotics (Foot)

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

Not Covered: Orthopedic shoes or examinations to prescribe or fit such shoes.

See Also:

Home/Durable Medical Equipment earlier in this section.

Prosthetic Devices later in this section.

Physical Therapy

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

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

Not Covered:

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

Physicians and Practitioners

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

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

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Licensed Marriage and Family Therapists.

Licensed Mental Health Counselors.

Medical Doctors (M.D.).

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

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology.

Speech Pathologists.

See Also:

Choosing a Provider, page 37.

Prescription Drugs

Covered:

- When you are an inpatient or outpatient of a facility.
- Any state sales tax associated with the purchase of a covered prescription drug.

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

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

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

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

Not Covered:

- Antigen therapy.
- Medication Therapy Management (MTM) when billed separately.
- Prescription drugs or pharmacy durable medical equipment devices that are not FDA-approved.
- Glucose strips.
- Insulin.
- Prescription drugs and devices used to treat nicotine dependence.
- Prescription drugs other than as stated earlier in this section.

See Also:

Contraceptives earlier in this section.

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

Notification Requirements and Care Coordination, page 45.

Preventive Care

Covered: Preventive care such as:

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

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

Benefits Maximum:

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

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

Not Covered:

- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel, or other administrative purposes.
- Group lactation consultant services.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

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

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

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.

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

Orthotics (Foot) earlier in this section.

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 breast surgery for cancer treatment, or prevention in high risk members, including lymphedemas.

See Also:

Cosmetic Services earlier in this section.

Self-Help Programs

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

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

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

Social Adjustment

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

Speech Therapy

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

Not Covered:

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

Surgery

Covered. This includes the following:

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

Not Covered:

- Bariatric surgery.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

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

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

Not Covered: Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission. You are also not covered for telehealth mental health and chemical dependency services from Doctor on Demand.

Temporomandibular Joint Disorder (TMD)

Covered.

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

Transplants

Covered:

You are covered for medically necessary transplants including, but not limited to:

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

- Pancreas.
- Small bowel.

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

Transplants are subject to case management.

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

Not Covered:

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

See Also:

Ambulance Services earlier in this section.

Case Management, page 50.

Travel or Lodging Costs later in this section.

Travel or Lodging Costs

Covered: Transportation and lodging costs are covered only when related to a covered transplant.

Benefits Maximum:

- **$10,000** per transplant, limited to **$200** per day for lodging and transportation.

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

See Also:

Transplants earlier in this section.

Vision Services

Covered:

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

Not Covered:

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

Wigs or Hairpieces

Covered: Wigs and hairpieces are covered but only when related to hair loss resulting from alopecia or chemotherapy and radiation treatment.

Benefits Maximum:

- **$300** per lifetime.

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, subject to the appeal procedures outlined later in this summary plan description. Wellmark's medically necessary analysis and determinations apply to any service, supply, device, or drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. Benefits are available only if the services are medically necessary services and are covered services under this summary plan description. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

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

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

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

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a 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 57.

General Exclusions

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

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

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

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

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

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

- You receive the services from an Out-of-Network Provider; or

- You receive the services from a 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.

See Also:

Clinical Trials, page 15.

Complications of a Noncovered Service or Services Related to Noncovered Services

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:

- A noncovered abortion.

Services, supplies, devices, or drugs that are administered primarily to support the provision or receipt of noncovered services are also not covered.

Nonmedical or Administrative Services

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

Provider Is Family Member

You are not covered for a service or supply received from a provider who is in your immediate family, which includes the following:

- Husband or wife;
- Natural or adoptive parent, child, or sibling;
- Stepparent, stepchild, stepbrother, or stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
- Grandparent or grandchild; and
- Spouse of grandparent or grandchild.

Covered by Other Programs or Laws

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

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

Workers' Compensation

You are not covered for services or supplies for which we learn or are notified by you, your provider, or our vendor that such services or supplies are related to a work related illness or injury, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. We will comply with our statutory obligation

regarding payment on claims on which workers' compensation liability is unresolved. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if:

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

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

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

Benefit Limitations

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

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered,* page 13.
- If you receive benefits that reach a lifetime benefits maximum applicable to any specific service, then you are no longer eligible for benefits for that service under this group health plan. See *Benefits Maximums*, page 5, and *At a Glance–Covered and Not Covered*, page 9.
- If you do not obtain precertification for certain medical services, benefits can be denied. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 45.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

  You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will

handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 45.

- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 37, and *Factors Affecting What You Pay*, page 51. An example of a charge that depends on the type of provider includes, but is not limited to:
  - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network Provider.

5. Choosing a Provider

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

It relies on a preferred provider organization (PPO) network, which consists of providers that participate directly with the Wellmark Blue PPO network 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 Out-of-Network. 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 in another state or service area, but not with a PPO.

Other providers are considered Out-of-Network, 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 51.

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

Providers are independent contractors and are not agents or employees of Wellmark Blue Cross and Blue Shield of Iowa. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 20 and *Physicians and Practitioners*, page 25.

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

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 Out-of-Network 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 that contract with our pharmacy benefits manager are considered in-network. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist, consult the directory of participating pharmacies on our website at *myWellmark.com*, or call the Customer Service number on your ID card.

Provider Comparison Chart	PPO	Participating	Out-of-Network
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	Yes	No
Minimizes your payment obligations. See *What You Pay*, 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*	Yes*	No

*If you visit a PPO or Participating 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

BlueCard Program

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

The BlueCard Program is one of the advantages of your coverage with Wellmark 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 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.

PPO Providers may not be available in some states. In this case, when you receive covered services from a non-PPO provider (i.e., a Participating or Out-of-Network provider), you will receive many of the same advantages as when you receive covered services from a PPO Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service. An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 4. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating

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

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 PPO or Participating 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 group health plan payment is sent directly to the providers.
- Wellmark requires claims to be filed within 365 days following the date of service (or 365 days from date of discharge for inpatient claims). However, if the PPO or Participating provider's contract with the Host Blue has a requirement that a claim be filed in a timeframe exceeding 365 days following the date of service or date of discharge for inpatient claims, Wellmark will process the claim according to the Host Blue's contractual filing requirement. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

Typically, when you receive covered services from PPO or Participating providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 45. However, if you are admitted to a BlueCard facility outside the Wellmark service area, any PPO or Participating provider should handle notification requirements for you.

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the Wellmark service area, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described in the following paragraphs.

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

When you receive covered services outside Wellmark's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for covered services; or

- The negotiated price that the Host Blue makes available to us.

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

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

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

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

The Maximum Allowable Fee for Out-of-Network Providers

When covered services are provided by Out-of-Network Providers, the maximum allowable fee may be determined by the provider type, provider location, and the availability of certain pricing methods. The maximum allowable fee is not based upon or related to a usual, customary or reasonable charge ("UCR"). In addition to the foregoing, the maximum allowable fee may, in Wellmark's sole and exclusive discretion, be subject in all respects to Wellmark's claim payment rules, edits and methodologies regardless of the provider's status as an in-network or Out-of-Network provider. Wellmark also may utilize Medicare claim rules or edits that are used by Medicare in processing similar claims. Pursuant to Wellmark payment policies, in determining a maximum allowable fee, we may bundle services, apply multiple procedure discounts and/or apply other reductions as a result of the procedures performed and billed on the claim. See *Maximum Allowable Fee*, page 54.

For covered services provided by an Out-of-Network Provider, the maximum allowable fee will be based upon one of the following payment options to be determined at Wellmark's sole and exclusive discretion:

- a percentage of covered charges;
- the Host Blue's Out-of-Network Provider local payment under the BlueCard Program;
- a percentage, not less than 50%, of the lowest contracted provider payment arrangement for a Wellmark Health Plan of Iowa, Inc., provider of the same provider type for the same or similar service (including, but not limited to, supplies or drugs) that was in effect on the date of admission (inpatient claims) or date of service (all other claims);
- a percentage, not less than 50%, of the lowest contracted provider payment arrangement for a Wellmark Blue PPO Provider of the same provider type for the same or similar service (including, but not limited to, supplies or drugs) that was in effect on the date of admission (inpatient claims) or date of service (all other claims);
- a special negotiated payment with the Out-of-Network Provider;
- pricing arrangements required by Iowa or South Dakota law; or
- a percentage of the national CMS payment rate for the same provider type and service. (For purposes of this bullet, Wellmark updates this rate once annually each July 1st using the national CMS payment rate (unadjusted based on

locality) that became effective for Medicare on January 1st of that same calendar year.)

Nothing in this summary plan description, including your plan's provider network designation, mandates that Wellmark select one of the foregoing payment options over another. The payment option selected by Wellmark under this paragraph may result in a maximum allowable fee that is a lower amount than if calculated by another payment option. You may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered services as set forth in this summary plan description.

An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 4. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us to the Out-of-Network Provider. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider, only if there is no Participating Provider who can furnish such item or service at such facility.

Care in a Foreign Country

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

Blue Cross Blue Shield Global® Core Program

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

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

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

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

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 75.

Submitting a Blue Cross Blue Shield Global Core Claim

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

Whenever possible, before receiving services outside the Wellmark service area, you should ask the provider if they participate 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.

Laboratory services. You may have laboratory specimens or samples collected by a PPO Provider and those laboratory specimens may be sent to another laboratory services provider for processing or testing. If that laboratory services provider does not have a contractual relationship with the Blue Plan where the specimen was drawn,* that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

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

Home/durable medical equipment. If you purchase or rent home/durable medical equipment from a provider that does not have a contractual relationship with the Blue Plan where you purchased or rented the equipment, that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the home/durable medical equipment provider, that provider will be considered Out-of-Network and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

Orthotics and prosthetic devices. If you purchase orthotics or prosthetic devices from a provider that does not have a contractual relationship with the Blue Plan where you purchased the orthotics or prosthetic devices, that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

If you purchase orthotics or prosthetic devices and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the provider, that provider will be considered Out-of-Network and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase orthotics or prosthetic devices and have them shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the provider.

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

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

See *Out-of-Network Providers,* page 53.

Continuity of Care

If you are a Continuing Care Patient

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

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

In order to elect transitional care as a Continuing Care Patient, you may respond to the letter Wellmark sends you, or you or

your provider may call us at **800-552-3993**.

6. Notification Requirements and Care Coordination

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

Providers and Notification Requirements
PPO or Participating providers in Iowa and South Dakota should handle notification requirements for you. If you are admitted to a PPO or Participating facility outside Iowa or South Dakota, the PPO or Participating provider should handle notification requirements for you.

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

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

You or your authorized representative, if you have designated one, may appeal a denial of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 85. Also see *Authorized Representative*, page 93.

Precertification

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

Person Responsible for Obtaining Precertification	**You** or someone acting on your behalf is responsible for obtaining precertification if: ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive certain planned outpatient procedures or home health services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota. **Your Provider** should obtain precertification for you if: ■ You receive services subject to precertification from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.
Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. Ask your provider for assistance gathering supporting information. After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.
Importance	If you choose to receive services subject to precertification, you will be responsible for the charges as follows: ■ If you receive services subject to precertification from an Out-of-Network Provider and we determine that the procedure was not medically necessary you will be responsible for the full charge. Denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *What You Pay*, page 3.

Notification

Purpose	Notification helps determine whether a service or admission to a facility is medically necessary. Notification is required; however, it does not apply to maternity inpatient stays under the two-day vaginal, four-day cesarean delivery timeframes or newborn stays.
Applies to	Generally, notification applies to inpatient admissions. For a complete list of the services subject to notification, visit *Wellmark.com/member/authorizations-and-approvals* or call the Customer Service number on your ID card.
Person Responsible	PPO Providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf is responsible for notification if: ■ You receive services subject to notification from a provider outside Iowa or South Dakota; ■ You receive services subject to notification from a Participating or Out-of-Network provider.
Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services or as soon as reasonably possible thereafter.
Importance	If you receive services subject to notification from an Out-of-Network Provider, you will be responsible for the charges as follows: ■ If we determine that the services billed by that Out-of-Network Provider were not medically necessary, you will be responsible for the full charge.

Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.
Applies to	For a complete list of the services subject to prior approval, visit *Wellmark.com/member/authorizations-and-approvals* or call the Customer Service number on your ID card.

Person Responsible for Obtaining Prior Approval	**You** or someone acting on your behalf is responsible for obtaining prior approval if: ■ You receive services subject to prior approval from an Out-of-Network Provider; or ■ You receive certain planned outpatient procedures or home health services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Your Provider** should obtain prior approval for you if: ■ You receive services subject to prior approval from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.
Process	When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form. Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.

Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits. Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended. **Note:** When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See *Precertification* and *Notification* earlier in this section.

Concurrent Review

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

Case Management

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

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

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

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

The benefit year is important for calculating:

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

How Coinsurance is Calculated

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

PPO Providers in the Wellmark Service Area and Out-of-Network Providers

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 31.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 4.

PPO and Participating Providers Outside the Wellmark Service Area

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

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 31.

Often, the negotiated price will be a simple discount that reflects an actual price the

local Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 31.

Laws in a small number of states may require the Host Blue Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Wellmark will calculate your payment obligation for any covered services according to applicable law. For more information, see *BlueCard Program*, page 38.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 4.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers.

PPO Providers

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

- The PPO payment obligation amounts may be waived or may be less than the Participating and Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 5.
- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and/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 provider.

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with Participating Providers. Pharmacies that contract with our pharmacy benefits manager are considered in-network. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist, consult the directory of participating pharmacies on our website at *myWellmark.com*, or call the Customer Service number on your ID card. When you receive services from Participating Providers:

- The Participating payment obligation amounts may be waived or may be less than the Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 5.

- These providers agree to accept Wellmark's payment arrangements, or 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 provider.

Out-of-Network Providers

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

- The following is true unless the No Surprises Act applies:

  You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider will generally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from Out-of-Network Providers. See *Services Outside the Wellmark Service Area,* page 38. However, when you receive services in an in-network facility and are provided covered services by an Out-of-Network ancillary provider, in-network cost-share will be applied and accumulate toward the out-of-pocket maximum. For this purpose, ancillary providers include pathologists, emergency room physicians, anesthesiologists, radiologists, or hospitalists. Because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you will still be responsible for any difference between the billed charge and our settlement amount for the services from the Out-of-Network ancillary provider unless the No Surprises Act applies.
- Wellmark does not make claim payments directly to these providers, and you are responsible for ensuring that your provider is paid in full, unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you, and you are responsible for forwarding the check to the provider (plus any billed balance you may owe), unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- When the No Surprises Act applies to your items or services, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a

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

Amount Charged and Maximum Allowable Fee

Amount Charged

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

Maximum Allowable Fee

The maximum allowable fee is the amount, established by Wellmark, using various methodologies, for covered services and supplies. In most instances, Wellmark's amount paid is based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee. In most instances, the maximum allowable fee for Out-of-Network Providers is less than the maximum allowable fee for in-network providers.

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 provider could be different from the covered charge. Regardless of the amount we pay a Participating or PPO provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you may be responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 31.
- *Medical Plan Paid*, 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

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

Provider Payment Arrangements

Provider payment arrangements are calculated using industry methods including, but not limited to, fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment

arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. 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.

8. Coverage Eligibility and Effective Date

Eligible Members

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

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

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

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

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

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

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

  Documentation will be required.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 61.

Eligibility Requirements

The following are eligibility requirements for participating in this health benefits plan.

Full-time Employees. A full-time employee means an employee who works a minimum of 30 hours per week. If you are a full-time employee, you are eligible to apply for coverage on your effective date as a full-time employee or at an annual enrollment of the group. See your employer or group sponsor for details.

Retirees. You and your covered dependents are eligible to continue participating under this health benefits plan if:

- You are covered under this plan at the time you retire; and

- You are between the ages of 55 and 65 and have met the criteria established by the school district; and
- You are in a class eligible for coverage; and
- You make application for IPERS benefits immediately when eligible; and
- You have made any required contributions.

Spouses of retirees who are under age 65 when the retiree's coverage terminates are age 65 may remain on the Plan until age 65, provided:

- The spouse is covered as a dependent at the time the employee retired (spouse acquired after the date of retirement may not be covered under the Plan); and
- The spouse agrees to and makes the applicable premium payment by the date established from time to time by the Plan Administrator.

Dependents acquired after the employee has retired are not eligible for dependent coverage.

Retired employees and their covered dependents are eligible to continue coverage under this Plan provided each of the conditions are met. Furthermore, on the date of retirement, coverage will continue as long as the retiree has elected to continue this coverage and there is no break in coverage.

When Coverage Begins

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

Late Enrollees

A late enrollee is a member who declines coverage when initially eligible to enroll and then later wishes to enroll for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity. See *Coverage Change Events*, page 61.

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

Changes to Information Related to You or to Your Benefits

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

Qualified Medical Child Support Order

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

A QMCSO specifies information such as:

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

A Qualified Medical Child Support Order cannot require that a benefits plan provide

any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

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

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

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

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

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

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

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

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

Family and Medical Leave Act of 1993

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

Any employee taking a leave under the FMLA shall be entitled to continue the employee's benefits during the duration of the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. **Please note:** The employee is

still responsible for paying their share of the premium if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the FMLA does not constitute a qualifying event so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of the approved period of Family and Medical Leave and terminates employment with employer, the COBRA qualifying event occurs at that time.

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

9. Coverage Changes and Termination

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

Coverage Change Events

Coverage Enrollment Events: The following events allow you or your eligible child to enroll for coverage. The following events may also allow your spouse to enroll for coverage if spouses are eligible for coverage under this plan. 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 eligible spouse or your dependent loses eligibility for creditable coverage or their employer or group sponsor ceases contribution to creditable coverage.
- Spouse (if eligible for coverage) loses coverage through their employer.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

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

- Dependent child resumes status as a full-time student.
- Addition of a biological child by court order. See *Qualified Medical Child Support Order*, page 58.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

Retiree Termination of Coverage: Coverage will end on the earliest of the following dates:

- The date the covered retiree ceases to be in a class of retirees eligible for coverage;
- The date this Plan is terminated with respect to an entire class of retirees to which such covered retiree belongs for coverage;
- The end of the period for which the covered retiree has made contributions if the covered retiree fails to make the next required contribution;
- The date this Plan is terminated with respect to the District, and there is no successor plan;
- Upon attaining age 65; or
- The date the covered retiree voluntarily elects to be terminated from the Plan.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

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

- Death.
- Divorce or annulment (if spouses are eligible for coverage under this plan). Legal separation, also, may result in removal from coverage. If you become legally separated, notify your employer or group sponsor.
- 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 (if spouses are eligible for coverage under this plan), your Medicare eligibility may terminate this coverage.

In case of the following coverage removal events, the affected child's coverage may be

continued until the end of the month on or after the date of the event:

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

Reinstatement of Child

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

- Involuntary loss of creditable coverage (including, but not limited to, group or *hawk-i* coverage).
- Loss of creditable coverage due to:
  - Termination of employment or eligibility.
  - Death of spouse.
  - Divorce.
- Court ordered coverage for spouse or minor children under the parent's health insurance.
- Exhaustion of COBRA or Iowa continuation coverage.
- The plan member is employed by an employer that offers multiple health plans and elects a different plan during an open enrollment period.
- A change in status in which the employee becomes eligible to enroll in this group health plan and requests enrollment. See *Coverage Enrollment Events* earlier in this section.

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

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

Requirement to Notify Group Sponsor

You must notify your employer or group sponsor of an event that allows you to add members or make changes to 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.
- Divorce, legal separation, or annulment.
- Your dependent child loses eligibility for coverage.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

For all other events, your employer or group sponsor must allow a minimum of 30 days for notification of an event that allows you to add members or make changes to the coverage status of members. See your employer or group sponsor for details.

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

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

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

Your group health plan will fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of the plan conflicts with USERRA, the conflicting provision will not apply. All other benefits and exclusions

of the group health plan will remain effective to the extent there is no conflict with USERRA.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and the employee's covered dependents during a period of the employee's active service or training with any of the uniformed services. The plan provides that a covered employee may elect to continue coverages in effect at the time the employee is called to active service. The maximum period of coverage for an employee and the covered employee's dependents under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the covered employee's absence begins; or
- The period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
  - For service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
  - For service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;
  - For service of more than 180 days, no later than 90 days after the completion of the period of service; or
  - For a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from the illness or injury. The period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the plan during a period of active service in the uniformed services may be required to pay no more than 102% of the full premium under the plan associated with the coverage for the employer's other employees. This is true except in the case of a covered employee who performs service in the uniformed services for less than 31 days. When this is the case, the covered employee may not be required to pay more than the employee's share, if any, for the coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the uniformed services and their family members are eligible to receive coverage under the TRICARE program (formerly CHAMPUS).

When a covered employee's coverage under a health plan was terminated by reason of service in the uniformed services, the preexisting condition exclusion and waiting period may not be imposed in connection with the reinstatement of the coverage upon reemployment under USERRA. This applies to a covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the preexisting condition exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the uniformed services.

Uniformed services includes full-time and reserve components of the United States Army, Navy, Air Force, Marines and Coast Guard, the Army National Guard, the commissioned corps of the Public Health

Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the uniformed service, you should check with the plan administrator for a more complete explanation of your rights and obligations under USERRA.

Coverage Termination

The following events terminate your coverage eligibility.

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

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

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

If you receive covered facility services as an inpatient of a hospital or a resident of a nursing facility on the date your coverage eligibility terminates, payment for the covered facility services will end on the earliest of the following:

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

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

Fraud or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

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

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

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

- We will retain legal rights, including the right to bring a civil action.

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

Any payment(s) remitted to Wellmark that are returned by the bank account holder's bank as unpaid will be subject to a returned payment fee. The bank account holder will be responsible for this fee.

The terms of reinstatement will require payment of a reinstatement fee. The notice will detail the amount due and the final deadline for the reinstatement payment to be made.

Coverage Continuation

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

COBRA Continuation
COBRA continuation coverage is a temporary extension of group health coverage under the plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available when you would otherwise lose group health coverage under the plan. It can also become available to your spouse and dependent children, if they are covered under the plan, when they would otherwise lose their group health coverage under the plan. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The description of COBRA coverage contained here applies only to the group health plan benefits offered under the plan and not to any other benefits offered by your employer or group sponsor (such as life insurance, disability, or accidental death or dismemberment benefits). The plan provides no greater COBRA rights than what COBRA requires. Nothing in the plan is intended to expand the participant's rights beyond COBRA's requirements.

Coverage Entitlement. You, your spouse, and/or your dependent child(ren) will be entitled to elect COBRA if you lose your group health coverage under the plan because of a life event known as a *qualifying event*. You may be entitled to continue this coverage under COBRA for a period of 18, 29, or 36 months depending on the qualifying event that causes loss of coverage under this plan. See *Length of Coverage* later in this section.

The following are recognized qualifying events that will entitle you, your spouse, and/or your dependent child(ren) for COBRA Coverage.

You will be entitled to elect COBRA:

- If you lose your group health coverage under the plan because your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will be entitled to elect COBRA if they lose their group health coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both) prior to your qualifying event; or
- Your spouse becomes divorced or legally separated from you.

Your dependent child will be entitled to elect COBRA if they lose their group health

coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both);
- You and your spouse become divorced or legally separated; or
- The dependent stops being eligible for coverage under the plan as a dependent child.

A child born to, adopted by, or placed for adoption with you during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA coverage for yourself. The child's COBRA coverage begins when the child is enrolled under this plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled under this plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Your child who is receiving benefits under this plan pursuant to a qualified medical child support order (QMCSO) received by your employer or group sponsor during your period of employment with your employer or group sponsor is entitled to the same rights to elect COBRA as your eligible dependent child.

If you take a Family and Medical Leave Act (FMLA) leave and do not return to work at the end of the leave or terminate coverage during the leave, you (and your spouse and dependent children, if any) will be entitled to elect COBRA if:

- They were covered under the plan on the day before the FMLA leave began or became covered during the FMLA leave; and
- They will lose coverage under the plan because of your failure to return to work at the end of the leave. This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the plan during the leave.

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period, subject to extension or early termination, generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. For information on how long you may have COBRA coverage, see later in this section, under *Length of Coverage*.

Qualifying Events. After a qualifying event occurs and any required notice of that event is properly provided to your employer or group sponsor, COBRA coverage must be offered to each person losing coverage under the plan who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the plan is lost because of the qualifying event.

COBRA coverage is the same coverage that this plan gives to other participants or beneficiaries under the plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the plan as other participants or beneficiaries covered under the component or components of this plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under this plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

When the qualifying event is the end of your employment, your reduction of hours of employment, or your death, COBRA coverage will be offered to qualified beneficiaries. You need not notify your employer or group sponsor of any of these three qualifying events.

For the other qualifying events, a COBRA election will be available only if you notify your employer or group sponsor in writing within 60 days after the later of:

- The date of the qualifying event; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event.

The written notice must include the plan name or group name, your name, your Social Security Number, your dependent's name and a description of the event.

Please note: If these procedures are not followed or if the written notice is not provided to your employer or group sponsor during the 60-day notice period, you or your dependents will lose your right to elect COBRA.

Electing Coverage. To elect COBRA, you must complete the Election form that is part of the COBRA election notice and submit it to Wellmark Blue Cross and Blue Shield of Iowa. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election form from your employer or group sponsor. Under federal law, you must have 60 days after the date the qualified beneficiary coverage under the plan terminates, or, if later, 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event to decide whether you want to elect COBRA under the plan.

Mail the completed Election form to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 3W395
Des Moines, IA 50309-2901

The Election form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

The election must be postmarked 60 days from the termination date or 60 days from the date the COBRA election notice provided at the time of the qualifying event. **Please note:** If you do not submit a completed Election form within this period, you will lose your right to elect COBRA.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election form before the due date. The plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

You do not have to send any payment with your Election form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You and your spouse (if your spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA election notice will lose their right to elect COBRA coverage.

When you complete the Election form, you must notify Wellmark Blue Cross and Blue Shield of Iowa if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election form, immediately notify Wellmark Blue Cross and Blue Shield of Iowa of the date of the Medicare entitlement

at the address specified above for delivery of the Election form.

Qualified beneficiaries may be enrolled in one or more group health components at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, they may elect COBRA under any or all of the group health components under which they were covered on the day before the qualifying event. For example, if a qualified beneficiary was covered under the medical and vision components on the day before a qualifying event, they may elect COBRA under the vision component only, the medical component only, or under both medical and vision (only if both components are available as a separate election option to the active employee).

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, they become entitled to Medicare benefits or becomes covered under other group health plan coverage. For information on when coverage will terminate, see later in this section, under *Termination of Coverage*.

When considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as coverage sponsored by the spouse's employer) within 30 days after your group health coverage under the plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available.

Length of Coverage. When coverage is lost due to your death, your divorce or legal separation, or your dependent child losing eligibility as a dependent child, COBRA coverage can last for up to a maximum of 36 months.

When coverage is lost due to the end of your employment or reduction in hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than you as the employee) who lose coverage as a result of the qualifying event can last a maximum of 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA coverage under the plan for your spouse and children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if you become entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when coverage is lost due to the end of your employment or reduction of hours of employment, COBRA coverage generally can last for only up to a maximum of 18 months.

Extending Coverage. If the qualifying event that resulted in your COBRA election was your termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer or group sponsor of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the

qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your employer or group sponsor in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was your termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify your employer or group sponsor in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of your termination of employment or reduction of hours; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of your termination of employment or reduction of hours.

The written notice must include the plan name or group name, your name, your Social Security Number, your dependent's name and a description of the event.

You must also provide this notice within 60 days after your termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to your employer or group sponsor during the 60-day notice period, then there will be no disability extension of COBRA coverage.

An extension of coverage will be available to your spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 60 days (or, in the case of a disability extension, the 29 months) following your termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include your death, your divorce or legal separation, or a dependent child's ceasing to be eligible for coverage as a dependent under this plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. (This extension is not available under this plan when you become entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies your employer or group sponsor in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; and
- The date on which the qualified beneficiary would lose coverage under the terms of this plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under this plan).

If these procedures are not followed or if the written notice is not provided to your employer or group sponsor during the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

For example, if disability ends June 10, coverage will continue through the month of July (7/31).

Termination of Coverage. Coverage under COBRA will end when you meet the maximum period for your qualifying event, as indicated earlier under *Length of Coverage*.

COBRA coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- The employer ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see *Extending Coverage,* earlier in this section.
- COBRA coverage may also be terminated for any reason this plan would terminate your coverage or coverage of a beneficiary not receiving COBRA coverage, such as fraud.

You must notify your employer or group sponsor in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage.

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. Your employer or group sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your employer or group sponsor of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your employer or group sponsor of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Your employer or group sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your employer or group sponsor that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see *Extending Coverage,* earlier in this section.

Coverage Cost and Payment. Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

All COBRA premiums must be paid by check or money order.

Your first payment and all monthly payments for COBRA coverage must be made payable to Wellmark Blue Cross and Blue Shield of Iowa and mailed to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 3W395
Des Moines, IA 50309-2901

The payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of election. This is the date the Election form is postmarked, if mailed, or the date the Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered. For more information on electing coverage, see *Electing Coverage* earlier in this section.

The first payment must cover the cost of COBRA coverage from the time coverage under the plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and make the first payment for it.

If you do not make the first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under this plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under this plan will continue for that month without any break.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under this plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the plan.

Assistance With Questions. Questions concerning the plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about *COBRA,* the *Health*

Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional Office of the U.S. Department of Health and Human Services (HHS) or visit the HHS website at www.hhs.gov. Addresses and phone numbers of Regional HHS Offices are also available through HHS's website.

Notification of Changes. In order to protect your family's rights, you should keep Wellmark Blue Cross and Blue Shield of Iowa informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices sent by your employer or group sponsor.

Plan Contact Information. For additional information about you and your dependents' rights and obligations under the plan and under federal law, you should contact your employer or group sponsor, the plan administrator. You may obtain information about COBRA coverage on request from:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 3W395
Des Moines, IA 50309-2901

The contact information for the plan may change from time to time. The most recent information will be included in the most recent plan documents (if you are not sure whether this is the most recent plan document, you may request the most recent one from the plan administrator or your employer or group sponsor).

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.

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

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

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

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

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

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

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

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

When to File a Claim

You need to file a claim if you:

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

Wellmark must receive claims within 365 days following the date of service of the claim (or 365 days from date of discharge for inpatient claims) or if you have other coverage that has primary responsibility for payment then within 365 days of the date of the other carrier's explanation of benefits. If you receive services outside of Wellmark's service area, Wellmark must receive the claim within 365 days following the date of service (or 365 days from date of discharge for inpatient claims) or within the filing requirement in the contractual agreement between the Participating Provider and the Host Blue. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

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

2. Fill Out the Claim Form

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

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

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

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

— Description of each service.

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

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

3. Sign the Claim Form

4. Submit the Claim

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

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

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

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

Notification of Decision

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

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

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

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 79.

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

Request for Benefit Exception Review

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

Services subject to this exception process:

- For a woman who previously has had breast cancer, ovarian cancer, or other cancer, but who has not been diagnosed with BRCA-related cancer, appropriate

preventive screening, genetic counseling, and genetic testing.

- For transgender individuals, sex-specific preventive care services (e.g., mammograms and Pap smears) that your attending provider has determined are medically appropriate.
- For dependent children, certain well-woman preventive care services that the attending provider determined are age- and developmentally-appropriate.
- Anesthesia services (or other integral services, such as polyp removal, collection of a specimen for recommended screenings, or a follow-up colonoscopy after a positive non-invasive stool-based screening test or direct visualization screening test) in connection with a preventive colonoscopy when your attending provider determined that anesthesia would be medically appropriate.
- A required consultation prior to a screening colonoscopy, if your attending provider determined that the pre-procedure consultation would be medically appropriate for you.
- If you received pathology services from an in-network provider related to a preventive colonoscopy screening for which you were responsible for a portion of the cost, such as a deductible, copayment or coinsurance.
- Certain immunizations that ACIP recommends for specified individuals (rather than for routine use for an entire population), when prescribed by your health care provider consistent with the ACIP recommendations.
- Contraceptive services and FDA-approved, cleared, or granted contraceptive products (including drugs and drug-led devices for which there is a covered therapeutic equivalent), if an individual's attending provider has determined the specific product or care to be medically appropriate for the individual. Other pre- or post-operative items and services integral to the contraceptive service, such as a pregnancy test or services integral to sterilization surgeries (including but not limited to tubal ligation).
- Services provided that are integral to the above listed preventive services.

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

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

11. Coordination of Benefits

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

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

Other Coverage

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

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

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

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

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

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

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 365 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

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

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

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

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Dependent Children

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

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
  - If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this *Dependent Children* section.
- For a dependent child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of this *Dependent Children* section, to the dependent child's parent or parents and the dependent's spouse.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

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

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited

to the amount we would have paid had this plan been primary.

- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 96.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

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

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

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

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

Coordination with Medicare

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

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

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

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

- Age 65 or older; and
- A current 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 in most situations Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by 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 eligibility if both of the following are true:

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

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

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

12. Appeals

Right of Appeal

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

- A precertification request.
- A notification of admission or services.
- A prior approval request.

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *Wellmark.com/member/forms*. See *Authorized Representative*, page 93.

Medically Urgent Appeal

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

Non-Medically Urgent Appeal

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

What to Include in Your Internal Appeal

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

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

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

Where to Send Internal Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232

Review of Internal Appeal

Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you prior to Wellmark issuing a final adverse benefit determination and you will have the

opportunity to respond to that information or to provide information.

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

Decision on Internal Appeal

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

Medically Urgent Appeal

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

All Other Appeals

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

External Review

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

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- A surprise bill.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 45.
- A rescission of coverage.

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

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

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

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

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on your request for external review.

Requests must be filed in writing at the following address, no later than four months

after you receive notice of the final adverse benefit determination:

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

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

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

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

You may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, concurrent review, or service for which you received emergency services, and you have not been discharged from a facility.

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

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

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

Arbitration and Legal Action

You shall not start arbitration or legal action against us until you have exhausted the appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 95, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

13. Arbitration and Legal Action

PLEASE READ THIS SECTION CAREFULLY

Mandatory Arbitration

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

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

Covered Claims

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

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

No Class Arbitrations and Class Actions Waiver

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

Claims Excluded from Mandatory Arbitration

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

AN ARBITRATOR DETERMINES A PARTICULAR CLAIM IS EXCLUDED FROM ARBITRATION BY FEDERAL OR STATE LAW, *CLAIMS EXCLUDED BY APPLICABLE LAW*, LATER IN THIS SECTION, AND *GOVERNING LAW*, PAGE 95, WILL APPLY TO THE PARTIES AND SUCH PARTICULAR CLAIM.

Arbitration Process Generally

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

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

Arbitration Fees and Other Costs

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

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

Confidentiality

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

Questions of Arbitrability

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

Claims Excluded By Applicable Law

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

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

Survival and Severability of Terms

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

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

14. General Provisions

Contract

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

- Any application you submitted to us or to your employer or group sponsor.
- Any agreement or group policy we have with your employer or group sponsor.
- Any application completed by your employer or group sponsor.
- This summary plan description and any 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 Summary Plan Description

We will interpret the provisions of this summary plan description 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 summary plan description. If any benefit described in this summary plan description is subject to a determination of medical necessity, unless otherwise required by law, we will make that factual determination. Our interpretations and determinations are final and conclusive, subject to the appeal procedures outlined earlier in this summary plan description.

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

Plan Year

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

Authority to Terminate, Amend, or Modify

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

Authorized Group Benefits Plan Changes

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

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 61.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at *Wellmark.com/member/forms* or by calling the Customer Service number on your ID card.

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

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

Release of Information

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

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

Privacy of Information

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

Treatment

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

Payment

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

Health Care Operations

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

Other Disclosures

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

disclosures permitted by your authorization while it was in effect.

Member Health Support Services

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

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

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

Value Added or Innovative Benefits

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

Value-Based Programs

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

Nonassignment

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

Governing Law

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

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

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

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

Enrollment Without Regard to Medicaid

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

Acquisition by States of Rights of Third Parties

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

Medicaid Reimbursement

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

Subrogation

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

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

Right of Subrogation

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

Right of Reimbursement

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

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

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

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

Procedures for Subrogation and Reimbursement

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

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or their attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or their 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 their 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 their insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or their insurer; and
- All other information requested by us.

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 5W580
Des Moines, IA 50309-2901

You also agree to all of the following:

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

of our right to reimbursement or subrogation has been resolved.

- In the event you invoke your rights of recovery against a third-party related to the illness or injury, you will not seek an advancement of costs or fees from us.
- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses, and the "make whole" rule is specifically rejected and inapplicable under this group health plan.
- We will not be liable for payment of any share of attorneys' fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing, and the "common fund" rule is specifically rejected and inapplicable under this group health plan.

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

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

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

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

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

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

Workers' Compensation

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

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

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

claim or to waive reimbursement of any claim, at our discretion.

Payment in Error

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

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

Notice

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

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue
Des Moines, IA 50309-2901

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

Submitting a Complaint

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

Consent to Telephone Calls and Text or Email Notifications

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

Glossary

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

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

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

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

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

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

Continuing Care Patient is an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious or complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Creditable Coverage. Any of the following categories of coverage:

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

Extended Home Skilled Nursing. Home skilled nursing care, other than short-term home skilled nursing, provided in the home by a registered (R.N.) or licensed practical nurse (L.P.N.) who is associated with an agency accredited by the

Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency that is ordered by a physician and consists of four or more hours per day of continuous nursing care that requires the technical proficiency and knowledge of an R.N. or L.P.N.

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

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

Habilitative Services. Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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

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

Medically Urgent. A situation where a longer, non-urgent response time could seriously jeopardize the life or health of the plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed without the services in question.

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

Member. A person covered under this group health plan.

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

Out-of-Network Provider. A facility or practitioner that does not participate with Wellmark or any other Blue Cross and/or Blue Shield Plan. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, Licensed Psychiatric or Mental Health Treatment Facility, Licensed Substance Abuse Treatment Facility, or the home.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO network. Pharmacies that contract with our pharmacy benefits manager are considered in-network.

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

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

PPO Provider. A facility or practitioner that participates with the Wellmark Blue PPO network or with a Blue Cross and/or Blue Shield PPO network in another state or service area.

Serious and Complex Condition. A condition, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to

avoid the reasonable possibility of death or permanent harm; or

- in the case of a chronic illness or condition, a condition that:
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

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

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

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

We, Our, Us. Wellmark 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

abortion 18
accidental injury 16
acupressure 13
acupuncture 9, 13
addiction 9, 14
administrative services 10, 24, 33
admissions 45, 47
adoption 57, 61
advanced registered nurse practitioners 11, 25
allergy services 9, 13
ambulance services 9, 13
ambulatory facility 20
ambulatory facility services 16
amount charged 54
anesthesia 9, 14, 16
annulment 61, 62
antigen therapy 26
appeals 45, 85
applied behavior analysis (ABA) 9, 14
arbitration 89, 90, 91
arbitration fees 91
assignment of benefits 95, 96
audiologists 11, 25
authority to terminate or amend 93
authorized representative 93
autism 9, 14

B

benefit coordination 79
benefit year 51
benefit year deductible 4
benefits maximums 5, 9
bereavement counseling 16
biological products 26
birth of child 61
blood 9, 14
BlueCard program 38, 51
bone marrow transplants 28
braces 19, 22, 27
brain injuries 50
breast reconstruction 27

C

care coordination 45
case management 50
changes of coverage 61, 62
chemical dependency 9, 14
chemical dependency treatment facility 20
chemotherapy 9, 15
child support order 58
children 57, 58, 61, 80
chiropractic services 10, 23
chiropractors 11, 25
claim filing 75, 79
claim forms 75
claim payment 76
claims 75
claims excluded by applicable law 91
class actions waiver 89
clinical trials 9, 15
COBRA coverage 61, 65
coinsurance 3, 4, 51
colonoscopy 26
communication disorders 23
community mental health center 20
complaints 99
complications 33
concurrent review 49
conditions of coverage 31
confidentiality 91
contact lenses 29
continuing care patient 43, 101
continuity of care 43, 101
contraceptives 9, 15
contract 93
contract amendment 93
contract interpretation 93, 95
convenience items 10, 22
conversion therapy 9, 15
coordination of benefits 79

coordination of care 45
cosmetic services 10, 15
cosmetic surgery 11, 27
counseling 10, 16
coverage changes 61, 62, 93
coverage continuation 65, 73
coverage effective date 58
coverage eligibility 57, 61
coverage termination 62, 64
covered claims 89
creditable coverage 61
custodial care 19
cystic fibrosis 50

D

death 61
deductible 4
deductible amounts 3
degenerative muscle disorders 50
dental services 10, 16
dependents 57, 58, 61, 80
diabetes 10, 17
diabetic education 10, 17
diabetic supplies 22
dialysis 10, 17
dietary products 10, 16, 24
disabled dependents 57
divorce 61, 62
doctors 11, 25
doctors of osteopathy 11, 25
drug abuse 9, 14
drugs 11, 26
drugs that are not FDA-approved 26

E

education 10, 16
effective date 58
eligibility for coverage 57, 61
emergency services 10, 17
employment physicals 27
EOB (explanation of benefits) 76
exclusions 31, 32
expedited external review 87
experimental services 32
explanation of benefits (EOB) 76
eye services 12, 29
eyeglasses 29

F

facilities 10, 20
family counseling 16
family deductible 4
family member as provider 33
fertility services 10, 17
filing claims 75, 79
foot care (routine) 21
foot doctors 11, 25
foreign countries 41
foster children 57, 61
fraud 64

G

genetic testing 10, 18
glucose strips 26
government programs 33, 79
gynecological examinations 26

H

hairpieces 12, 29
hearing services 10, 18
hemophilia 50
high risk pregnancy 50
home health services 10, 18
home infusion therapy 26
home office (Wellmark) 99
home/durable medical equipment 10, 18, 19
hospice respite care 19
hospice services 10, 19
hospital services 16, 64
hospitals 10, 20

I

ID card 37, 38
illness 10, 20
impacted teeth 16
infertility treatment 10, 17, 21
information disclosure 94
inhalation therapy 10, 18, 21
injury 10, 20
inpatient facility admission 45, 47
inpatient services 51, 64

insulin 26
investigational services 32

K

kidney dialysis 17

L

L.P.N. 18
laboratory services 12, 29
late enrollees 58
licensed independent social workers 11, 25
licensed practical nurses 18
lifetime benefits maximum 34
limitations of coverage 5, 9, 31, 34
lodging 11, 29
long term acute care facility 20
long term acute care services 21

M

mammogram (3D) 26
mammograms 11, 26
marriage 61
marriage and family therapists 11, 25
marriage counseling 16
massage therapy 24
mastectomy 27
maternity services 10, 21
maximum allowable fee 54
medicaid enrollment 96
medicaid reimbursement 96
medical doctors 11, 25
medical equipment 10, 18, 19
medical supplies 10, 22
medical support order 58
medically necessary 31
Medicare 61, 79
medication therapy management 26
medicines 11, 26
mental health counselors 11, 25
mental health services 10, 22
mental health treatment facility 20
mental illness 10, 22
military service 33
misrepresentation of material facts 64
motor vehicles 10, 23
muscle disorders 50
musculoskeletal treatment 10, 23

N

network savings 54
newborn children 61
nicotine dependence 26
nonassignment of benefits 95
nonmedical services 10, 24, 33
notice 99
notification of change 62
notification requirements 45
nursing facilities 20, 64
nutritional counseling 10, 24
nutritional products 10, 16, 24

O

occupational therapists 11, 25
occupational therapy 10, 18, 24
optometrists 11, 25
oral contraceptives 15
oral surgeons 11, 25
organ transplants 11, 28
orthotics (foot) 10, 25
osteopathic doctors 11, 25
other insurance 33, 79
out-of-area coverage 38, 51
out-of-network providers 53
out-of-pocket maximum 4
oxygen 18, 22

P

Pap smears 26
participating providers 37, 52
payment arrangements 54
payment in error 99
payment obligations 3, 5, 31, 35, 46, 51
personal items 10, 22
physical examinations 11, 26
physical therapists 11, 25
physical therapy 11, 19, 25
physician assistants 11, 25
physicians 11, 25
plan year 93
plastic surgery 10, 15
podiatrists 11, 25
PPO providers 37, 52

practitioners 11, 25
precertification 34, 45
preferred provider organization (PPO) 37
pregnancy 21
pregnancy (high risk) 50
prenatal services 21
prescription drugs 11, 26
preventive care 11, 26
prior approval 34, 47
privacy 94
prosthetic devices 11, 19, 27
provider network 3, 37, 52
psychiatric medical institution for children (PMIC) 20
psychiatric services 22
psychologists 11, 25
public employees 72
pulmonary therapy 10, 18, 21

Q

qualified medical child support order 58

R

R.N. 11, 18, 21, 25
radiation therapy 9, 15
reconstructive surgery 11, 27
registered nurses 11, 18, 21, 25
reimbursement of benefits 96, 99
release of information 94
removal from coverage 61
respiratory therapy 10, 18, 21
rights of appeal 85
routine services 11, 26

S

self-help 11, 27
separation 61, 62
serious and complex condition 43, 102
service area 38
short-term home skilled nursing 18
skilled nursing services 18
sleep apnea 11, 28
social adjustment 11, 28
social workers 11, 25
speech pathologists 11, 25
speech therapy 11, 28
spinal cord injuries 50
sports physicals 27
spouses 57, 61
stepchildren 57
sterilization 21
students 57, 62
subrogation 96
surgery 11, 28
surgical facility 20
surgical facility services 16
surgical supplies 10, 22
survival and severability of terms 91

T

take-home drugs 26
telehealth 11, 28
temporomandibular joint disorder 11, 28
termination of coverage 62, 64
third party liability 33
TMD (temporomandibular joint disorder). 11, 28
tooth removal 16
transplants 11, 28, 50
travel 11, 29
travel physicals 27
tubal ligation 17

U

urgent care center 20

V

vaccines 26
vasectomy 17
vehicles 10, 23
vision services 12, 29

W

well-child care 11, 26
wigs 12, 29
workers' compensation 33, 98

X

x-rays 12, 29

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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