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

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

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

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

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

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

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

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

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

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

Your coverage includes many services, treatments, supplies, devices, and drugs. Throughout the coverage manual, the words services or supplies refer to any services, treatments, supplies, devices, or drugs, as applicable in the context, that may be used to diagnose or treat a condition.
Grandfathered Health Plan Status
This group health plan was in effect on March 23, 2010 and is being categorized as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”).

As permitted under the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted and does not have to include certain consumer protections that apply to non-grandfathered health plans, such as coverage of preventive health services without any cost-sharing obligation. (Certain other consumer protections such as the elimination of lifetime limits on benefits apply to all group health plans, regardless of their status as a grandfathered health plan.)

For questions regarding which consumer protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status contact your employer or group sponsor.

You may also contact the U.S. Department of Health and Human Services (HHS) at www.hhs.gov.

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.
# Plan Description

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>Iowa State University HMO Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Sponsor:</td>
<td>Iowa State University of Science and Technology</td>
</tr>
<tr>
<td>Employer ID Number:</td>
<td>42-6004224</td>
</tr>
<tr>
<td>Plan Number:</td>
<td>501</td>
</tr>
<tr>
<td>When Plan Year Ends:</td>
<td>January 31</td>
</tr>
<tr>
<td>Participants of Plan:</td>
<td>All persons who are disabled or retired employees as defined by the employer’s or group sponsor’s eligibility requirements. (Also see Coverage Eligibility and Effective Date, page 51.)</td>
</tr>
</tbody>
</table>
| Plan Administrator and Agent for Service of Legal Process: | Iowa State University of Science and Technology  
Department of Human Resource Services Benefits Office  
3770 Beardshear Hall  
Ames, IA 50011-2033  
Phone Number: 515-294-4800 |
| How Plan Costs Are Funded:     | Active employees may or may not be required to contribute toward the cost of a single plan of health care, depending upon which plan you are enrolled in. You are required to contribute toward the cost of yourself and spouse/domestic partner, yourself and children, or yourself and family coverage. The contribution will be deducted from your pay at a rate established by the University. If you are employed on other than a 12-month basis, the necessary amount will be deducted from your last regular paycheck to maintain coverage for the off-duty period. For example, if you are employed on a regular nine-month basis and you will be returning to regular employment with the commencement of classes in August, a deduction will be made from your May 31st paycheck to cover your coverage through August 31st. The University will not contribute toward the cost of regular retiree coverage. A retired employee under age 65 will pay the full rate for an active employee. A retired employee age 65 or older will pay the rate for a retired employee, and may elect to cover his or her dependent spouse or domestic partner under the two-person rate. A retiree with dependent children will pay the appropriate tier rate. Iowa State University does not process premium payments. Arrangements for paying premiums should be made with Wellmark. The retiree may contact Wellmark Customer Service at 800-494-4478 to request an Automatic Withdrawal form to have the premium paid directly from their bank account. Otherwise, the retiree will be billed monthly by Wellmark. |
| Type of Plan:                  | Group Health Plan               |
| Type of Administration:       | Self-Funded                     |
| Benefits Administered by:     | Wellmark Health Plan of Iowa, Inc.  
1331 Grand Avenue  
Des Moines, IA 50309-2901 |

If this plan is maintained by two or more employers, a complete list of the employers sponsoring the plan may be obtained on written request to the plan administrator.
1. What You Pay

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

Provider Network

Under the medical benefits of this plan, your network of providers consists of your designated personal doctor, which may also be referred to as your designated primary care provider (PCP), and Wellmark Health Plan Network Providers. All other providers are not in your network. Which provider type you choose will affect what you pay.

Generally, you are only covered for services received from your designated personal doctor or from Wellmark Health Plan Network Providers; however, you may be covered for services received from Participating Providers in the case of an emergency, guest membership, or approved referrals. You may be covered for services received from Out-of-Network Providers in the case of an emergency or approved Out-of-Network referrals.

Designated Personal Doctor. Your designated personal doctor, which may also be referred to as your designated PCP, evaluates your medical condition and either treats your condition or coordinates services you require. You must choose a personal doctor from the Wellmark Health Plan Network. You have the right to choose any personal doctor who participates in the Wellmark Health Plan Network and who is available to accept you or your family members. You may select one of the following types of providers as your designated personal doctor: family practitioners, general practitioners, internists, nurse practitioners, physicians assistants, and pediatricians.

Wellmark Health Plan Network Providers. These providers participate with the Wellmark Health Plan Network. Throughout this coverage manual we will refer to these providers as “Network Providers.” With Blue Advantage, benefits for most covered services are generally available only when received from Wellmark Health Plan Network Providers.

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

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

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.
### Payment Details

**Copayment**

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

**Emergency Room Copayment.**

The emergency room copayment:

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

**Office Visit Copayment.**

The office visit copayment:

- applies to the office exam only, acupuncture, and musculoskeletal manipulations.
- is taken once per practitioner per date of service.

**Urgent Care Center Copayment.**

The urgent care center copayment:

- applies to the exam only received from:
  - Network Providers in Iowa classified by Wellmark as Urgent Care Centers.
- is taken once per provider per date of service.

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

**Benefits Maximums**

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

Benefits maximums are accumulated from benefits under this medical benefits plan and prior medical benefits plans sponsored by your employer or group sponsor and administered by Wellmark Health Plan of Iowa, Inc.
**Waived Payment Obligations**
Some payment obligations are waived for the following covered services.

<table>
<thead>
<tr>
<th>Covered Service</th>
<th>Payment Obligation Waived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health conditions and chemical dependency treatment – office services.</td>
<td>Copayment</td>
</tr>
<tr>
<td>Physician services related to maternity care.</td>
<td>Copayment</td>
</tr>
</tbody>
</table>
2. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this coverage manual. Many of these terms and conditions are contained in Details – Covered and Not Covered, page 13. To fully understand which services are covered and which are not, you must become familiar with this entire coverage manual. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

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

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

**Not Covered.** The listed category is generally not covered.

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

**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 Health Plan of Iowa, Inc.

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered</th>
<th>Not Covered</th>
<th>See Page</th>
<th>Benefits Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture Treatment</td>
<td>●</td>
<td></td>
<td>13</td>
<td>$500 per benefit year.</td>
</tr>
<tr>
<td>Allergy Testing and Treatment</td>
<td>●</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>●</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Anesthesia</td>
<td>●</td>
<td></td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Blood and Blood Administration</td>
<td>●</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Chemical Dependency Treatment</td>
<td>●</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>●</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td>●</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Cosmetic Services</td>
<td>◎</td>
<td></td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Counseling and Education Services</td>
<td>◎</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Dental Treatment for Accidental Injury</td>
<td>●</td>
<td></td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>●</td>
<td></td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>
## At A Glance – Covered and Not Covered

<table>
<thead>
<tr>
<th>Category</th>
<th>Covered</th>
<th>Not Covered</th>
<th>Benefits Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Services for Diabetes and Nutrition</td>
<td>●</td>
<td>15</td>
<td>10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to two hours annually.</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>●</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Fertility and Infertility Services</td>
<td>●</td>
<td>16</td>
<td>$15,000 per lifetime for infertility transfer procedures.</td>
</tr>
<tr>
<td>Genetic Testing</td>
<td>●</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Hearing Services</td>
<td>●</td>
<td>17</td>
<td>One routine hearing examination per benefit year.</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>●</td>
<td>17</td>
<td>The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.</td>
</tr>
<tr>
<td>Home/Durable Medical Equipment</td>
<td>●</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Hospice Services</td>
<td>●</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Hospitals and Facilities</td>
<td>●</td>
<td>18</td>
<td>120 days per benefit year of skilled nursing services in a hospital or nursing facility.</td>
</tr>
<tr>
<td>Illness or Injury Services</td>
<td>●</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>●</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td>●</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Medical and Surgical Supplies</td>
<td>●</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Medicare Part B Drugs</td>
<td>●</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>●</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Morbid Obesity Treatment</td>
<td>●</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Motor Vehicles</td>
<td>●</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal Treatment</td>
<td>●</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Nicotine Dependence</td>
<td>●</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Nonmedical Services</td>
<td>●</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>●</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Orthotics</td>
<td>●</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>●</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>Physicians and Practitioners</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Registered Nurse Practitioners</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Audiologists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Chiropractors</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Doctors of Osteopathy</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Licensed Acupuncturists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Licensed Independent Social Workers</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Covered</td>
<td>Not Covered</td>
<td>See Page</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------</td>
<td>-------------</td>
<td>----------</td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Optometrists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Oral Surgeons</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Physical Therapists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Podiatrists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Speech Pathologists</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>●</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>●</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Self-Help Programs</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Sleep Apnea Treatment</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>●</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular Joint Disorder (TMD)</td>
<td>●</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Transplants</td>
<td>●</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Travel or Lodging Costs</td>
<td>●</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Vision Services</td>
<td>●</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Wigs or Hairpieces</td>
<td>●</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>X-ray and Laboratory Services</td>
<td>●</td>
<td>27</td>
<td></td>
</tr>
</tbody>
</table>

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

$10,000 per transplant. This limit also includes transplant travel by ambulance.

One routine vision examination per benefit year.
3. **Details - Covered and Not Covered**

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this coverage manual. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 29. If a service or supply is not specifically listed, do not assume it is covered.

---

**Acupuncture Treatment**

**Covered:** Acupuncture treatment. Acupuncture is a treatment in which the skin is penetrated with needles in order to stimulate certain points on the body. This may or may not be accompanied by electrical stimulation.

**Benefits Maximum:**
- $500 per benefit year.

**Not Covered:** Acupressure treatment.

---

**Allergy Testing and Treatment**

**Covered.**

---

**Ambulance Services**

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

All of the following are required to qualify for benefits:

- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility in the Wellmark Health Plan Network with adequate facilities to treat your medical condition and it is accessible by your designated personal doctor. In an emergency situation, you should seek care at the nearest appropriate facility, whether the facility is in-network or out-of-network.
- During transportation, your medical condition requires the services that are provided only by an ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility in an emergency.
- In addition to the preceding requirements, for air ambulance services to be covered, all of the following conditions must be met:
  - The air ambulance has the necessary patient care equipment and supplies to meet your needs.
  - Your medical condition requires immediate and rapid ambulance transport that cannot be provided by a ground ambulance; or the point of pick up is inaccessible by a land vehicle.
  - Great distances, limited time frames, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment.
  - Your condition is such that the time needed to transport you by land poses a threat to your health.

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

**Anesthesia**

**Covered:** Anesthesia and the administration of anesthesia.
Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Blood and Blood Administration
Covered: Blood and blood administration, 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 as described in the most current Diagnostic and Statistical Manual of Mental Disorders.

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

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

Not Covered:
- Treatment received in a residential treatment facility, except as described under Covered.

See Also:
Hospitals and Facilities later in this section.

Chemotherapy and Radiation Therapy
Covered: Use of chemical agents or radiation to treat or control a serious illness.

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.

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

See Also:
Reconstructive Surgery later in this section.
Counseling and Education Services

Not Covered:

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

See Also:

*Genetic Testing* later in this section.

*Education Services for Diabetes and Nutrition* later in this section.

*Mental Health Services* later in this section.

Dental Services

Covered:

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

Not Covered:

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

Dialysis

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

Education Services for Diabetes and Nutrition

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

All covered training or education must be prescribed by a licensed physician. Outpatient training or education must be provided by a state-certified program.
The state-certified diabetic education program helps any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.

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

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

**Benefits Maximum:**

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

**Emergency Services**

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

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

In an emergency situation, if you cannot reasonably reach a Wellmark Health Plan Network Provider, covered services will be reimbursed as though they were received from a Wellmark Health Plan Network Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

**See Also:**

*Out-of-Network Providers*, page 47.

**Fertility and Infertility Services**

**Covered:**

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

**Benefits Maximum:**

- $15,000 per lifetime for infertility transfer procedures.

**Not Covered:**

- Infertility treatment if the infertility is the result of voluntary sterilization.
- The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures or for any other reason or service; freezing of sperm, oocytes, or embryos; surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

**See Also:**

*Prescription Drugs* later in this section.

**Genetic Testing**

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

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

**Hearing Services**

**Covered:**
- Routine hearing examinations.

**Benefits Maximum:**
- One routine hearing examination per benefit year.

**Not Covered:**
- Hearing aids.

**Home Health Services**

**Covered:** All of the following requirements must be met in order for home health services to be covered:
- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by Wellmark for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is referred by your designated personal doctor or a Network Provider and approved by Wellmark.

The following are covered services and supplies:

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

- **Short-Term Home Skilled Nursing.** Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Short-term home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. The daily benefit for short-term home skilled nursing services will not exceed Wellmark’s daily maximum allowable fee for care in a skilled nursing facility. Custodial care is not included in this benefit.

- **Inhalation Therapy.**

- **Medical Equipment.**

- **Medical Social Services.**

- **Medical Supplies.**

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

- **Oxygen and Equipment** for its administration.

- **Parenteral and Enteral Nutrition,** 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
Details – Covered and Not Covered

paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitaria care or rest cures.

- Extended home skilled nursing.

**See Also:**

*Referrals*, page 34.

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**Home/Durable Medical Equipment**

**Covered:** Equipment that meets all of the following requirements:

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

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

**See Also:**

*Medical and Surgical Supplies* later in this section.

*Orthotics* later in this section.

*Personal Conveniences Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 31.

*Prosthetic Devices* later in this section.

*Referrals*, page 34.

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**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.

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**Hospitals and Facilities**

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

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

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

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

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

- **Nursing Facility.** This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis. The facility must be licensed as a nursing facility under applicable law.
Residential Treatment Facility.
This is a licensed facility other than a hospital or nursing facility that provides:

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

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

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

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

Benefits Maximum:

- 120 days per benefit year for skilled nursing services in a hospital or nursing facility.

Not Covered:

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

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

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

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

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

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

Maternity Services
Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.
Please note: You must notify us or your employer or group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your employer or group sponsor or call the Customer Service number on your ID card.

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

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

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

If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

See Also:
Coverage Change Events, page 55.

Medical and Surgical Supplies
Covered: Medical supplies and devices such as:

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

Not Covered:

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

See Also:
Home/Durable Medical Equipment earlier in this section.
Orthotics later in this section.
Personal Convenience Items in the section General Conditions of Coverage, Exclusions, and Limitations, page 31.
Prosthetic Devices later in this section.

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

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

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

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

- The disorder is classified as a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) or subsequent revisions.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of International Classification of Diseases, Clinical Modification used for diagnosis coding.
- The disorder is not a chemical dependency condition.
The disorder is a behavioral or psychological condition not attributable to a mental disorder that is the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered covered under your medical benefits.

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

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

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

**Not Covered:** Treatment for:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nonpervasive developmental and learning disorders.

- Sensitivity, shyness, and social withdrawal disorders.
- Sexual disorders.
- Treatment received in a residential treatment facility, except as described under **Covered**.

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

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**Morbid Obesity Treatment**

**Covered:** Weight reduction surgery provided the surgery is medically necessary for your condition. Not all procedures classified as weight reduction surgery are covered.

**Not Covered:**

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

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**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.

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**Musculoskeletal Treatment**

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

**Not Covered:** Massage therapy.

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**Nicotine Dependence**

**Covered:** Medical evaluations related to nicotine dependence.

**Not Covered:** Prescription drugs and devices used to treat nicotine dependence.
Nonmedical Services
Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy, and any services or supplies that are nonmedical. You are also not covered for services delivered to you by a provider via interactive audio only, audio-visual technology, or web-based mobile device or similar electronic-based communication network.

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

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

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

Orthotics
Covered: 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.
Personal Convenience Items in the section General Conditions of Coverage, Exclusions, and Limitations, page 31.
Prosthetic Devices later in this section.
Referrals, page 34.

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

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

Not Covered:
- Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Physical therapy performed for maintenance.
- Physical therapy services that do not meet the requirements specified under Covered.
Physicians and Practitioners
Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

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

Audiologists.
Chiropractors.
Doctors of Osteopathy (D.O.).
Licensed Acupuncturists.
Licensed Independent Social Workers.
Medical Doctors (M.D.).
Occupational Therapists.
Optometrists.
Oral Surgeons.
Physical Therapists.
Physician Assistants.
Podiatrists.
Psychologists. Psychologists must have a doctorate degree in psychology with two years’ clinical experience and meet the standards of a national register.

Speech Pathologists.

Not Covered:

- Athletic Trainers.

See Also:
Choosing a Provider, page 33.

Prescription Drugs
Covered:

- When you are an inpatient or outpatient of a facility.
- Drugs eligible for coverage under Medicare Part B (primarily practitioner-administered injectable drugs) when you are enrolled in Medicare Part B.
- Any state sales tax associated with the purchase of a covered prescription drug.

Prescription drugs and medicines covered under your medical benefits include:

Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. Drugs eligible for coverage under Medicare Part B (primarily practitioner-administered injectable drugs) when you are enrolled in Medicare Part B. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

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

Self-Administered Injectable Drugs. Self-administered injectable drugs are generally covered under your prescription drug benefits. However, there are exceptions where self-administered injectable drugs may be covered under your medical benefits (e.g., drugs given in the muscle or through a vein). For a list of these drugs, visit our website at Wellmark.com or check with your pharmacist or physician.
**Not Covered:**
- Self-administered injectable drugs billed by a pharmacy.
- Drugs eligible for coverage under Medicare Part B when you are not enrolled in Medicare Part B.
- Drugs and biologicals purchased from or administered by a retail pharmacy.
- Diabetic supplies, including glucose strips, when this plan pays primary to Medicare.
- Prescription drugs that are not FDA-approved.
- 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* earlier in this section.
*Notification Requirements and Care Coordination*, page 41.

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**Preventive Care**

**Covered:**
- Physical examinations and related preventive services such as:
  - Digital breast tomosynthesis (3D mammogram).
  - Gynecological examinations.
  - Immunizations.
  - Mammograms.
  - Pap smears.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Generally, to qualify for benefits, you must receive preventive care from your designated personal doctor or from your designated OB/GYN care provider.

However, there are exceptions:
- You may receive influenza or pneumonia immunizations from Network Public Health Agencies, Network Visiting Nurse Associations, or covered Network specialists.
- You may receive all other covered immunizations from Network Public Health Agencies or Network Visiting Nurse Associations.
- You may receive your preventive gynecological examination from your selected OB/GYN.

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

**Not Covered:**
- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

**See Also:**
*Hearing Services* earlier in this section.
*Vision Services* later in this section.
Details – Covered and Not Covered

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

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

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.
Medical and Surgical Supplies earlier in this section.
Orthotics earlier in this section.
Personal Convenience Items in the section General Conditions of Coverage, Exclusions, and Limitations, page 31.
Referrals, page 34.

Reconstructive Surgery
Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:
Cosmetic Services earlier in this section.

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

Sleep Apnea Treatment
Covered: Obstructive sleep apnea diagnosis and treatments.

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

Speech Therapy
Covered: Rehabilitative speech therapy services when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered:

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

Surgery
Covered. This includes the following:

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

See Also:
Dental Services earlier in this section.
Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD) Covered.

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

Transplants are subject to case management.

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

To qualify for benefits, the transplant services listed earlier must be from a Wellmark Health Plan Network facility. This requirement does not apply to kidney transplants.

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

See Also:
Case Management, page 45.
Referrals, page 34.
Travel or Lodging Costs later in this section.

Travel or Lodging Costs Covered: Travel and lodging costs are covered when related to a transplant received more than 100 miles from the member’s home. Covered services include travel costs of the patient’s travel companion, or two travel companions if the covered patient is a dependent child.

Benefits Maximum:
- $10,000 per transplant. This limit also includes transplant travel by ambulance.

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

See Also:
Transplants earlier in this section.

Vision Services Covered: Routine vision examinations.

Benefits Maximum:
- One routine vision examination per benefit year.

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

Wigs or Hairpieces
Not Covered.
X-ray and Laboratory Services


See Also:

Preventive Care earlier in this section.
4. General Conditions of Coverage, Exclusions, and Limitations

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

Conditions of Coverage

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

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

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

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

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

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

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the Network or Participating provider is responsible for these amounts.
You are also responsible for the cost if you receive services from a provider outside of the Network 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 51.

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

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

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

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

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

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

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

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

You are also responsible for the cost if you receive services from a provider outside of the Network that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.
Complications of a Noncovered Service
You are not covered for a complication resulting from a noncovered service, supply, device, or drug. However, this exclusion does not apply to the treatment of complications resulting from:

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

Nonmedical Services
You are not covered for telephone consultations, charges for missed appointments, charges for completion of any form, or charges for information. You are also not covered for services delivered to you by a provider via interactive audio only, audio-visual technology, or web-based mobile device or similar electronic-based communication network.

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

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

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

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

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

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

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

Benefit Limitations
Benefit limitations refer to amounts for which you are responsible under this group health plan. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefit maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See Details – Covered and Not Covered, page 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
If you do not obtain precertification for certain medical services, benefits can be denied. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A Network Provider in the Wellmark Health Plan Network will handle notification requirements for you. If you see a provider outside the Wellmark Health Plan Network, you are responsible for notification requirements. See Notification Requirements and Care Coordination, page 41.

If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the Appeals section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits. You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A Network Provider in the Wellmark Health Plan Network will handle notification requirements for you. If you see a provider outside the Wellmark Health Plan Network, you are responsible for notification requirements. See Notification Requirements and Care Coordination, page 41.

The type of provider you choose can affect your benefits and what you pay. See Choosing a Provider, page 33, and Factors Affecting What You Pay, page 47. Examples of charges that depend on the type of provider include but are not limited to:

- Any difference between the provider’s amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network practitioner.
5. Choosing a Provider

Provider Network
Under the medical benefits of this plan, your network of providers consists of your designated personal doctor, which may also be referred to as your designated primary care provider (PCP), and Wellmark Health Plan Network Providers. All other providers are not in your network.

Your medical benefits are called Blue Advantage.

Providers who participate with the network utilized by these medical benefits are called designated personal doctors and Wellmark Health Plan Network Providers. See Designated Personal Doctor later in this section.

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

With Blue Advantage, it is usually to your advantage to visit your designated personal doctor for most covered services. If your designated personal doctor, or designated PCP, is unable to diagnose or treat your condition, he or she may refer you to another Network Provider. Generally, benefits are available only when received from your personal doctor or other Network Providers.

To determine if a provider participates with this medical benefits plan, ask your provider, refer to our online provider directory at Wellmark.com, or call the Customer Service number on your ID card.

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

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

Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist or call the Customer Service number on your ID card.

Designated Personal Doctor
Your designated personal doctor, which may also be referred to as your designated PCP, evaluates your medical condition and either treats your condition or coordinates services you require. You must choose a personal doctor from the Network. You have the right to choose any personal doctor who participates in our Network and who is available to accept you or your covered family members.

You may select one of the following types of providers as your designated personal doctor:

- General/Family Practice Physicians
- Internists
- Nurse Practitioners
Choosing a Provider

- Physician Assistants
- Pediatricians

All covered family members must select a personal doctor for claims to be paid, including covered family members who live outside the network area (for example, college students). Each member may choose his or her own personal doctor. For a covered child, you may choose a pediatrician as the designated personal doctor.

If your designated personal doctor is not available, he or she will designate a backup provider.

If your designated personal doctor leaves the Network, you will be notified and required to choose another personal doctor.

For information on how to select a personal doctor or for a list of participating personal doctors, call the Customer Service number on your ID card or visit our website, Wellmark.com.

Changing Your Designated Personal Doctor. If you or a covered family member decides to switch to a different designated personal doctor or OB/GYN, submit a change form, or call the Customer Service number on your ID card. Changes will be in effect by the first day of the month following receipt of your request.

Obstetrical/Gynecological (OB/GYN) Services. Female members may receive gynecological services from their designated personal doctor or choose an obstetrical/gynecological (OB/GYN) care provider from the Network.

You do not need consent from us or a personal doctor in order to obtain obstetrical or gynecological services from a Network practitioner who specializes in obstetrics or gynecology. However, the practitioner may be required to comply with certain procedures, such as obtaining prior approval or precertification for certain services, following a case management plan, or procedures for making referrals.

When you need gynecological care, you may either contact your personal doctor or your selected OB/GYN care provider and receive benefits.

For a list of Network practitioners who specialize in obstetrics or gynecology, call the Customer Service number on your ID card or visit our website, Wellmark.com.

Preventive Care

Generally, when you need preventive care, you must receive services from your personal doctor or your selected OB/GYN care provider to receive benefits. Most preventive care received from a provider other than your personal doctor or your selected OB/GYN care provider is not covered, with certain exceptions:

Influenza and Pneumonia Immunizations. You may receive influenza or pneumonia immunizations from Network Public Health Agencies, Network Visiting Nurse Associations, or covered Network specialists.

All Other Immunizations. You may receive all other covered immunizations from Network Public Health Agencies or Network Visiting Nurse Associations.

Preventive Gynecological Examination. You may receive your preventive gynecological examination from your designated personal doctor or your selected OB/GYN.

Vision Examinations

You may receive vision examinations from a Network optometrist or Network ophthalmologist.

Referrals

If you require services from a provider other than your designated personal doctor, typically a specialist, you may see a provider in the Network. If you require services that are not available from a specialist within the Network, you will be referred to a provider outside the Network who has expertise in diagnosing and treating your condition.
Wellmark must approve referrals outside of the Wellmark Health Plan Network before you receive services or the services will not be covered. Please note: Even when your referral outside the Wellmark Health Plan Network is approved, you are still responsible for complying with notification requirements. See Notification Requirements and Care Coordination, page 41.

Services Outside the Wellmark Health Plan Network

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

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

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

When you receive covered services from Participating Providers outside the Wellmark Health Plan Network, all of the following statements are true:

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

Typically, when you receive covered services from Participating Providers outside the Wellmark Health Plan Network, you are responsible for notification requirements. See Notification Requirements and Care Coordination, page 41. However, if you are admitted to a BlueCard facility outside the Wellmark Health Plan Network, any Participating Provider should handle notification requirements for you.

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

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers (“Participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some providers (“Out-of-Network Providers”)
Choosing a Provider

I don’t contract with the Host Blue. In the following paragraphs we explain how we pay both kinds of providers.

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

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

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

The BlueCard Program enables you to obtain covered out-of-area services, as defined previously in this section, from a healthcare provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the covered out-of-area services provided to you, so there are no claim forms for you to fill out. You will be responsible for your payment obligations. See Referrals earlier in this section. In addition notification requirements may apply, See Notification Requirements and Care Coordination, page 41

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

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

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

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

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

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.
Out-of-Network Providers Outside the Wellmark Service Area

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

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

Change of Residence

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

Care in a Foreign Country

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

Blue Cross Blue Shield Global™ Program

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

If you need medical assistance services (including locating a doctor or hospital) outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you should call the Blue Cross Blue Shield Global 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 Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global 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
Choosing a Provider

precertification for non-emergency inpatient services.

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See Claims, page 59.

Submitting a Blue Cross Blue Shield Global Claim
When you pay for covered services outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global International claim form and send the claim form with the provider’s itemized bill(s) to the Blue Cross Blue Shield Global 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, Blue Cross Blue Shield Global Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Service Center at 800-810-BLUE (2583) or call collect at 804-673-1177, 24 hours a day, seven days a week.

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

- Accidental Injuries.
- Emergencies.

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

- Out-of-Network Providers are not responsible for filing your claims.

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

See Out-of-Network Providers, page 47.

- Continuity of Care. You may be eligible to continue care from an Out-of-Network Provider for treatment of a terminal illness, a complex medical condition, or during the second or third trimester of pregnancy if:
  - You had been receiving care for the condition from a Wellmark Health Plan Network Provider but the provider’s contract with us terminates; or
  - You were previously covered by a different carrier or plan and had been receiving care for the condition from an Out-of-Network Provider when you begin coverage under your medical benefits.

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

- Terminal illness (as determined by the provider): for 90 days after the provider’s contract terminates or the patient begins coverage with Wellmark while under the care of an Out-of-Network Provider for treatment of the terminal illness, whichever applies.
- Complex medical condition: for a time period or benefit maximum determined by medical management. You or your provider must notify us before receiving services under these medical benefits, and the medical condition
must warrant continued treatment by the Out-of-Network Provider.

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

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

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

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

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

Before you leave the Wellmark Health Plan Network area, call the Customer Service number on your ID card to set up a guest membership.

**Laboratory services.** You may have laboratory specimens or samples collected by a Network Provider and those laboratory specimens may be sent to another laboratory services provider for processing or testing. If that laboratory services provider does not have a contractual relationship with the Blue Plan where the specimen was drawn, the service will not be covered and you will be responsible for the entire amount charged.

**Home/durable medical equipment.** If you purchase or rent home/durable medical equipment from a provider that does not have a contractual relationship with the Blue Plan where you purchased or rented the equipment, the service will not be covered and you will be responsible for the entire amount charged.

If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the home/durable medical equipment provider, the service will not be covered and you will be responsible for the entire amount charged. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in the Wellmark Health Plan Network, 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, the service will not be covered and you will be responsible for the entire amount charged. This includes situations where you purchase orthotics or prosthetic devices and have them shipped to you in the Wellmark Health Plan Network, when Wellmark does not have a contractual relationship with the provider.

**Talk to your provider.** Whenever possible, before receiving laboratory services, home/durable medical equipment, 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.

See Out-of-Network Providers, page 47.
6. Notification Requirements and Care Coordination

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

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

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a Participating Provider outside the Wellmark Health Plan Network, you or someone acting on your behalf are responsible for notification requirements.

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

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See Appeals, page 65. Also see Authorized Representative, page 69.

Precertification

<table>
<thead>
<tr>
<th>Purpose</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies to</td>
<td>For a complete list of the services subject to precertification, visit Wellmark.com or call the Customer Service number on your ID card.</td>
</tr>
</tbody>
</table>
You or someone acting on your behalf are responsible for obtaining precertification if:
- You receive services subject to precertification from an Out-of-Network Provider; or
- You receive non-inpatient services subject to precertification from a Participating Provider outside the Wellmark Health Plan Network.

**Please note:** Services from Out-of-Network Providers or from Participating Providers must be approved through the Referral process described on page 34, except in cases of an emergency or guest membership.

**Your Provider** should obtain precertification for you if:
- You receive services subject to precertification from a Wellmark Health Plan Network Provider in Iowa; or
- You receive inpatient services subject to precertification from a Participating Provider outside the Wellmark Health Plan Network.

**Please note:** If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.

When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services.

Wellmark will respond to a precertification request within:
- 72 hours in a medically urgent situation;
- 15 days in a non-medically urgent situation.

Precertification requests must include supporting clinical information to determine medical necessity of the service or admission.

After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.

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**Notification**

<table>
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<tr>
<th>Purpose</th>
<th>Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.</th>
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</thead>
<tbody>
<tr>
<td>Applies to</td>
<td>For a complete list of the services subject to notification, visit Wellmark.com or call the Customer Service number on your ID card.</td>
</tr>
</tbody>
</table>
| Person Responsible | Wellmark Health Plan Network Providers perform notification for you. However, you or someone acting on your behalf are responsible for notification if:  
- You receive services subject to notification from an 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.

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### Prior Approval

**Purpose** | Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.

**Applies to** | For a complete list of the services subject to prior approval, visit Wellmark.com or call the Customer Service number on your ID card.

**Person Responsible for Obtaining Prior Approval** | You or someone acting on your behalf are responsible for obtaining prior approval if:

- You receive services subject to prior approval from an Out-of-Network Provider; or
- You receive non-inpatient services subject to prior approval from a Participating Provider outside the Wellmark Health Plan Network.

**Please note:** Services from Out-of-Network Providers or from Participating Providers must be approved through the Referral process described on page 34, except in the cases of an emergency or guest membership.

**Your Provider** should obtain prior approval for you if:

- You receive services subject to prior approval from a Wellmark Health Plan Network Provider in Iowa; or
- You receive inpatient services subject to prior approval from a Participating Provider outside the Wellmark Health Plan Network.

**Please note:** If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.

**Process** | When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.

Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within:

- 72 hours in a medically urgent situation.
- 15 days in a non-medically urgent situation.

Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.
**Importance**

If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefit maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial.

If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval.

Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the Appeals section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits.

Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.

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**Concurrent Review**

**Purpose**

Concurrent review is a utilization review conducted during a member’s facility stay or course of treatment at home or in a facility setting to determine whether the place or level of service is medically necessary. This care coordination program occurs without any notification required from you.

**Applies to**

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

**Person Responsible**

Wellmark

**Process**

Wellmark may review your case to determine whether your current level of care is medically necessary.

Responses to Wellmark’s concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.

**Importance**

Wellmark may require a change in the level or place of service in order to continue providing benefits. If we determine that your current facility setting or level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.
# Case Management

**Purpose**
Case management is intended to identify and assist members with the most severe illnesses 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 life-time management. Examples where case management might be appropriate include but are not limited to:

- Brain or Spinal Cord Injuries
- Cystic Fibrosis
- Degenerative Muscle Disorders
- Hemophilia
- Pregnancy (high risk)
- Transplants

**Person Responsible**
You, your physician, and the health care facility can work with Wellmark’s case managers. Wellmark may initiate a request for case management.

**Process**
Members are identified and referred to the Case Management program through Customer Service and claims information, referrals from providers or family members, and self-referrals from members.

**Importance**
Case management is intended to identify and coordinate appropriate care and care alternatives including reviewing medical necessity; negotiating care and services; identifying barriers to care including contract limitations and evaluation of solutions outside the group health plan; assisting the member and family to identify appropriate community-based resources or government programs; and assisting members in the transition of care when there is a change in coverage.
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 for facility services will renew and will be based on the benefit limitations and payment obligation amounts in effect on the date you were admitted. However, your payment obligations 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:

- Benefit maximum.

**Provider Network**

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

**Participating Providers**

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

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

**Network Providers**

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

- You are eligible for benefits when care is received from your personal doctor. There may be exceptions to this rule for specific services. If so, these are described in the section Details – Services Covered and Not Covered.
- The Network payment obligation amounts may be waived for certain covered services. See Waived Payment Obligations, page 7.

There may be certain exceptions to these rules. Any exceptions are described in What You Pay.

**Out-of-Network Providers**

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with Out-of-Network Providers, and they may not accept our payment arrangements. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. Therefore, when you receive services from Out-of-Network Providers:
You are not eligible for benefits. There may be exceptions to this rule for specific services. If so, these are described in the section Details – Services Covered and Not Covered.

You are responsible for any difference between the amount charged and the maximum allowable fee for a covered service when the maximum allowable fee is less than the practitioner’s charge. This is not true when services are received from a covered oral surgeon or services are related to acupuncture. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider may be the lesser of Wellmark’s maximum allowable fee or the amount allowed by the Blue Cross or Blue Shield Plan in the state where the provider is located. See Services Outside the Wellmark Health Plan Network, page 35.

Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.

The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider (plus any billed balance you may owe).

Amount Charged and Maximum Allowable Fee

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

Maximum Allowable Fee
The maximum allowable fee is the amount, established by Wellmark, using various methodologies, for covered services and supplies. Wellmark’s amount paid may be based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee.

Payment Arrangements

Payment Arrangement Savings
Wellmark has contracting relationships with Network Providers. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

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

- **Network Savings**, which reflects the amount you save on a claim by receiving services from a Participating or Network provider. For the majority of services, the savings reflects the actual amount saved on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or Network provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.

- **Amount Not Covered**, which reflects the portion of provider charges not covered under your health benefits and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; reductions or denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see General Conditions of Coverage, Exclusions, and Limitations, page 29.
Factors Affecting What You Pay

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

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

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

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

**Wellmark Drug List**
Most prescription drugs are covered under a separate drug program offered by your employer, and not under your medical benefits.

Information about the Wellmark Drug List and rebates from drug manufacturers applies only to those drugs (such as injectable drugs) that may be covered under your medical benefits.

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

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

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

The Wellmark Drug List is subject to change.

**Pharmacy Benefits Manager**

**Fees and Drug Company Rebates**
Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services. Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark health coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group’s use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to us by the pharmacy benefits manager. We will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.
8. Coverage Eligibility and Effective Date

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

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

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

A 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 he or she meets the following criteria:
  - Claimed as a dependent on the employee’s, plan member’s, subscriber’s, policy holder’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 55.

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 55.

A late enrollee may not enroll for coverage at any time.

**Changes to Information Related to You or to Your Benefits**

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

**Qualified Medical Child Support Order**

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

A QMCSO specifies information such as:

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

A Qualified Medical Child Support Order cannot require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

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

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

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

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

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

- The court or administrative order requiring coverage in a group health plan is no longer in effect;
- The dependent’s eligibility for or enrollment in a comparable benefits plan that takes effect on or before the date the dependent’s enrollment in this group health plan terminates; or
- The employer eliminates dependent health coverage for all employees.
The employer or group sponsor is not required to maintain the dependent’s coverage if:

- You or your spouse no longer pay premiums because the employer or group sponsor no longer owes compensation; or
- You or your spouse have terminated employment with the employer and have not elected to continue coverage.
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 or domestic partner to enroll for coverage if spouses or domestic partners 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 his or her employer or group sponsor ceases contribution to creditable coverage.
- Spouse (if eligible for coverage) loses coverage through his or her employer.
- You lose eligibility for coverage under Medicaid or the Children’s Health Insurance Program (CHIP) (the hawk-i plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

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

- Dependent child resumes status as a full-time student.
- Addition of a natural child by court order. See *Qualified Medical Child Support Order*, page 52.
- Appointment as a child’s legal guardian.
- Placement of a foster child in your home by an approved agency.

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

- Death.
- Divorce or annulment. 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, your Medicare eligibility may terminate this coverage.

**Reinstatment of Child**

**Reinstatement Events.** A child up to age 26 who was removed from coverage may be reinstated on his or her 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 changes the coverage status of members. Notify your employer or group sponsor within 60 days in case of the following events:

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

For all other events, you must notify your employer or group sponsor within 60 days of the event.

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

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 similar coverage plans by giving written notice to you and your employer or group sponsor at least 90 days prior to termination.
- We decide to nonrenew all health benefit plans delivered or issued for delivery to employers in Iowa by giving written notice to your employer or group sponsor and the Director 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 on the last day of the month following the month your employment ends. When your coverage terminates for all other reasons, check with your employer or group sponsor or call the Customer Service number on your ID card to verify the coverage termination date.

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

- The end of your remaining days of coverage under this benefits plan.
- The date you are discharged from the hospital or nursing facility following termination of your coverage eligibility.
Coverage Changes and Termination

- A period not more than 60 days from the date of termination.

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

**Fraud or Intentional Misrepresentation of Material Facts**

Your coverage will terminate immediately if:

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

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

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

**Nonpayment**

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

**Coverage Continuation**

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

**COBRA Continuation**

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

**Continuation for Public Group**

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

**Continuation Under Iowa Law**

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

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

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

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

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

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

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

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

Once you receive medical services 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.

When to File a Claim
You need to file a claim if you:

- Use a provider who does not file claims for you. Wellmark Health Plan Network Providers file claims for you.

Wellmark must receive claims within 180 days following the date of service of the claim.

How to File a Claim
All claims must be submitted in writing.

1. Get a Claim Form
Forms are available at Wellmark.com or by calling the Customer Service number on your ID card or from your personnel department.

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

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

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

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

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

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

3. Sign the Claim Form

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

Wellmark Health Plan of Iowa, Inc.
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 61.

Once we pay your claim, whether our payment is sent to you or to your provider, our obligation to pay benefits for the claim is discharged. However, we may adjust a claim due to overpayment or underpayment for up to 18 months after we first process the claim. In the case of 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.
11. Coordination of Benefits

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

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

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

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

Other Coverage

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

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

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

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

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

Your Wellmark Health Plan Network Provider will forward your coverage information to us. If you have 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. 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, policy holder, 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, policy holder 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, policy holder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

- The coverage with the earliest continuous effective date pays first if none of the rules above apply.

- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.
Dependent Children
To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

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

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

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

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

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

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

**Coordination with Medicare**

Medicare is by law the secondary coverage to group health plans in a variety of situations. **Please note:** For a member covered by Medicare Part A, benefits under this medical benefits plan will be coordinated with benefits available under Medicare Part A and Part B, even if the member is not enrolled in Medicare Part B. When the member is not enrolled in Medicare Part B, and Medicare otherwise would be the primary payer under Medicare Secondary Payer regulations if the member were enrolled in Medicare Part B, Wellmark will calculate its payment responsibility by reducing its Maximum Allowable Fee calculation by 80%. Therefore, a member enrolled in Medicare Part A should also consider enrolling in Medicare Part B.

The following provisions apply only if you have both Medicare and employer “retiree/disabled” group health coverage under your medical benefits and your employer has the required minimum number of employees.

**Medicare Part B Drugs**

Drugs paid under Medicare Part B are then 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 Medicare is the secondary payer if the beneficiary is:

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

**Working Disabled**

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

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by an employer group health plan.

**End-Stage Renal Disease (ESRD)**

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

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

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

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

**When Medicare is the Primary Payer**

When Medicare is the primary coverage to this medical benefits plan, any payments this medical benefits plan makes as the secondary coverage are not subject to deductible, coinsurance, or copayments.
12. Appeals

Right of Appeal
You have the right to one full and fair review in the case of an adverse benefit determination that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim 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. See Authorized Representative, page 69.

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

Review of Internal Appeal
Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination.

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

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

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

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

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

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 41.

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

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

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

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

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

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

Iowa Insurance Division  
Two Ruan Center  
601 Locust, 4th Floor  
Des Moines, IA 50309-3738  
Fax: 515-281-3059  
E-mail: iid.marketrelegation@iid.iowa.gov

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

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

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

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

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

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

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

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

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

- Any application you submitted to us or to your employer or group sponsor.
- Any agreement or group policy we have with your employer or group sponsor.
- Any application completed by your employer or group sponsor.
- This coverage manual and any riders or amendments.

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

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

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

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

Authorized Group 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 coverage manual. This coverage manual cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent’s eligibility for coverage. See Coverage Changes and Termination, page 55.

Member Participation
You will be provided regular communication regarding matters such as wellness, general health education, and matters of policy and operation of Wellmark Health Plan of Iowa, Inc.

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

In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form.
An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You may authorize only one person as your representative at a time. You may revoke the authorized representative at any time.

**Release of Information**

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

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

**Privacy of Information**

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

**Treatment**

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

**Payment**

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

**Health Care Operations**

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

**Other Disclosures**

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

**Member Health Support Services**

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

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

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

Value Added or Innovative Benefits
Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include Blue 365, 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, Blue Cross Blue Shield Association, or other Blue Cross Blue Shield health plans (“Blue Plans”). Wellmark and Blue Plans have entered into collaborative arrangements with value-based programs under which the health care providers participating in them are eligible for financial incentives relating to quality and cost-effective care of Wellmark members. Your claims information may be used by the value-based program and any providers involved in such value-based program.

Health Insurance Portability and Accountability Act of 1996

Group Sponsor’s Certification of Compliance
Your group health plan, any business associate servicing your group health plan, or Wellmark will not disclose protected health information to your group sponsor unless your group sponsor certifies that group health plan documents have been modified to incorporate this provision and agrees to abide by this provision. Your receipt of this coverage manual means that your group sponsor has modified your group health plan documents to incorporate this provision, and has provided certification of compliance to Wellmark.

Purpose of Disclosure to Group Sponsor
Your group health plan, any business associate servicing your group health plan, or Wellmark will disclose protected health information to your group sponsor only to permit the group sponsor to perform plan administration of the group health plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by your group sponsor of protected health information will be subject to and consistent with the provisions identified under Restrictions on Group Sponsor’s Use and Disclosure of Protected Health Information and Adequate Separation Between the Group Sponsor and the Group Health Plan, later in this section.
Neither your group health plan, nor Wellmark, or any business associate servicing your group health plan will disclose protected health information to your group sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan members.

Neither your group health plan, nor Wellmark, or any business associate servicing your group health plan will disclose protected health information to your group sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the group sponsor.

Restrictions on Group Sponsor’s Use and Disclosure of Protected Health Information
Your group sponsor will not use or further disclose protected health information, except as permitted or required by this provision, or as required by law.

Your group sponsor will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the restrictions and conditions of this provision with respect to protected health information and electronic protected health information.

Your group sponsor will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the group sponsor.

Your group sponsor will report to the group health plan, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in this provision promptly upon learning of such inconsistent use or disclosure.

Your group sponsor will make protected health information available to plan members in accordance with 45 Code of Federal Regulations §164.524.

Your group sponsor will make protected health information available, and will on notice amend protected health information, in accordance with 45 Code of Federal Regulations §164.526.

Your group sponsor will track disclosures it may make of protected health information so that it can provide the information required by your group health plan to account for disclosures in accordance with 45 Code of Federal Regulations §164.528.

Your group sponsor will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your group health plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your group sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the group health plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, your group sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Your group sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information.

Your group sponsor will promptly report to the group health plan any of the following incidents of which the group sponsor becomes aware:

- unauthorized access, use, disclosure, modification, or destruction of the group health plan’s electronic protected health information, or
unauthorized interference with system operations in group sponsor’s information systems that contain or provide access to group health plan’s electronic protected health information.

Adequate Separation Between the Group Sponsor and the Group Health Plan
Certain individuals under the control of your group sponsor may be given access to protected health information received from the group health plan, a business associate servicing the group health plan, or Wellmark. This class of employees will be identified by the group sponsor to the group health plan and Wellmark from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business. These individuals will have access to protected health information only to perform the plan administration functions that the group sponsor provides for the group health plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the group sponsor, for any use or disclosure of protected health information in violation of or noncompliance with this provision. The group sponsor will promptly report such violation or noncompliance to the group health plan, and will cooperate with the group health plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

Your group sponsor will ensure that these provisions for adequate separation between the group sponsor and the group health plan are supported by reasonable and appropriate security measures.

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

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

Legal Action
You shall not start any legal action against us unless you have exhausted the applicable appeal process and the external review process described in the Appeals section. You shall not bring any legal or equitable action against us because of a claim under this group health plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in which the services or supplies were provided.

Medicaid Enrollment and Payments to Medicaid
Assignment of Rights
This group health plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits pursuant to Title XIX of the Social Security Act (Medicaid).
Enrollment Without Regard to Medicaid
Your receipt or eligibility for benefits under Medicaid will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of benefits.

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

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

Subrogation

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

You agree to recognize our rights under this group health plan to subrogation and reimbursement. These rights provide us with a priority over any money paid by a third party to you relative to the amount paid by this group health plan, including priority over any claim for non-medical charges, or other costs and expenses. We will assume all rights of recovery, to the extent of payment made under this group health plan, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement
You or your legal representative must do whatever we request with respect to the exercise of our subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform us in writing if you 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, within seven (7) days of such illness or injury to us as a condition to receipt of benefits:
General Provisions

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

Send this information to:

Wellmark Health Plan of Iowa, Inc.
1331 Grand Avenue, Station 5E151
Des Moines, IA 50309-2901

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.
- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid under this group health plan in connection with the illness or injury) in trust for the benefit of this group health plan as trustee(s) for us until the extent of our right to reimbursement or subrogation has been resolved.
- In the event you invoke your rights of recovery against a third-party related to the illness or injury, you will not seek an advancement of costs or fees from us.
- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf against the third party or his insurer; and
- All other information requested by us.

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 of benefits paid under this plan from your employer, your employer’s workers’ compensation carrier, or you in the event that your claim is accepted or adjudged to be covered under workers’ compensation.

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

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

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

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

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

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

Member Rights and Responsibilities

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

**Member Rights**

All Wellmark members have a right to:

- Receive accurate information about the group health plan, its services, its network of providers, and its members’ rights and responsibilities;
- Receive accurate information on utilization management notification requirements and case management services.
- Be treated with respect, in a manner that preserves their dignity and recognizes their right to privacy;
- Participate fully, with their providers, in decision-making that affects their health care;
- Expect a candid discussion of all appropriate or medically necessary treatment options pertaining to their conditions, regardless of cost or benefit coverage;
- Voice complaints or appeals about the group health plan or the care delivered by any of the providers;
- Make recommendations regarding Wellmark’s members’ rights and responsibilities policy.

**Member Responsibilities**

Likewise, Wellmark members share responsibility for maintaining their own good health. Specifically, all Wellmark members have a responsibility to:

- Provide, to the extent possible, information that the health plan needs to process claims, and information the providers need to provide care for them;
- Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible;
- Follow the plans and instructions for care that they have agreed to with their providers;
- Present their ID card prior to receiving services.

**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.
Glossary

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

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

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

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

**Backup Provider.** Your personal doctor’s designated backup when your personal doctor is not available. A backup provider is in the Wellmark Health Plan Network and performs the same functions as a designated personal doctor.

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

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

**Creditable Coverage.** Any of the following categories of coverage:

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

**Domestic Partner.** A domestic partner is a person, of the same or opposite sex, who is in a committed relationship solely with the covered ISU employee. A committed relationship is defined as exhibiting all of the following:

- Both partners intend to continue the relationship indefinitely;
- Neither partner is married or another person’s domestic partner;
- Both partners are 18 years of age or older and not related in a way that would otherwise bar marriage;
- Both partners agree to support one another and share significant resources for the benefit of their union.

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

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

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

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

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

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

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

**Member.** A person covered under this group health plan.

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

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

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

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

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

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

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

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

You, Your. The plan member and family members eligible for coverage under this group health plan.
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Required Federal Accessibility and Nondiscrimination Notice

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HH3I Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).
