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BluePriority HSASM
Health Plans
FOR INDIVIDUALS AND FAMILIES

ALLIANCE SELECTSM HSA-QUALIFIED PPO PLANS

OUTLINE OF COVERAGE
for Non-Grandfathered Plans

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You should read your certificate carefully. This Outline of Coverage for Blue Priority HSA/ Alliance Select Qualified health plans provides a brief description of the important features of your certificate. This is not your certificate. Only the actual benefit provisions in your certificate will determine your benefits. The certificate itself sets forth in detail the rights and obligations of both you and Wellmark Blue Cross and Blue Shield of Iowa.

THEFORE, IT IS IMPORTANT THAT YOU READ YOUR CERTIFICATE CAREFULLY.

Premium payments and service fees¹ may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example:

Payment Frequency	Description
Monthly	Premium and service fee payment would be for the first day of the month through the last day of such month through electronic funds transfer (EFT) only.
Quarterly	Premium and service fee payment is made through electronic funds transfer (EFT) only. Standard quarterly periods are: <ul style="list-style-type: none"> • January 1 through March 31 • April 1 through June 30 • July 1 through September 30 • October 1 through December 31
Semi-Annual	Premium and service fee payment would be for the calendar period of either <ul style="list-style-type: none"> • January 1 through June 30, or • July 1 through December 31
Annual	Premium and service fee payment would be for January 1 through December 31 of the applicable year.

In any year in which there is a mid-year adjustment in the amount of premium(s) and/or service fee(s), the Member will have the following obligations:

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

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

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

¹ A component of your total cost is the service fee. This fee, charged on a monthly basis, reflects a portion of the administrative costs of reviewing, administering, and maintaining contracts.

Terms to Know

Alliance Select Network is Wellmark's preferred provider organization (PPO) network. All Alliance Select health plans are supported by our extensive Alliance Select PPO network in Iowa, and through BlueCard PPO nationwide. Your out-of-pocket expenses may be less when seeking care from a PPO network provider.

Deductible is the fixed dollar amount you pay for most covered services before benefits are available during a benefit period. There are individual and family deductibles.

Family Deductible can be met through any combination of family members. The entire family deductible amount must be met before benefits are payable from the Blue Priority HSA/Alliance Select Qualified Plan.

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive services.

The provider you choose affects how your coinsurance is calculated and is based on:

- The billed charge for covered services received in an Alliance Select network provider's office.
- The payment arrangement amount minus deductible and contract limitations for all covered services provided by other providers in Iowa and South Dakota.
- The local Plan's payment arrangement amount minus deductible and contract limitations for covered services received outside of Iowa or South Dakota.

Out-of-Pocket Maximum (OPM) is the amount you pay out of your pocket for most covered services during a benefit period. The deductible, coinsurance, and applicable drug copayments apply toward meeting the OPM.

Network Savings is the amount saved due to contracts Wellmark Blue Cross and Blue Shield of Iowa has with providers.

Payment Arrangements are determined using various methods, including negotiated fees, based upon our contracting relationships with providers. These payment arrangements usually result in provider savings and can affect how your coinsurance is calculated.

Types of payment arrangements are:

- **Billed Charge** — The amount a provider bills for any services whether or not they are covered under your certificate.
- **Covered Charge** — The amount a provider bills for services covered under your certificate.
- **Maximum Allowable Fee** — The amount we establish, using various methods, for covered services.
- **Balance Billing** — The difference between a provider's charge and our maximum allowable fee for a specific service, procedure, or product. When you visit a non-participating provider, you are responsible for this difference. Balance billed amounts do not apply toward your deductible or out-of-pocket maximum and do not qualify for coinsurance benefits.

Health Savings Account (HSA) is a tax advantaged savings account that allows you to set aside pre-tax money to pay for qualified medical expenses such as office visits, prescription drugs, dental expenses, and laboratory tests. Contributions to an HSA are tax deductible and can earn tax-free interest.¹ You decide how and when to use your HSA funds. For example, you may use your HSA to pay for your qualified health care expenses until you meet your health plan deductible or you may save the funds to pay for future qualified medical expenses. Unlike other reimbursement-type plans, money in an HSA can accumulate indefinitely but you can only contribute to the account while you have HSA qualified health plan coverage.

Many financial institutions, including banks and credit unions, offer HSAs. For more information on how to set up these accounts, please contact your authorized Wellmark representative.

¹ State tax treatment may vary.

BluePriority HSASM

BLUE PRIORITY HSA PLANS pair an Alliance Select qualified high-deductible PPO health plan with a health savings account (HSA). The Blue Priority HSA/Alliance Select Qualified High-Deductible PPO health plans outlined here and detailed in the certificates are designed to provide you coverage for hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care. Covered services are subject to deductible and coinsurance provisions, or other limitations set forth in the certificate.

This coverage is available to you (“single” coverage), or to you and your family (“two person” or “family” coverage, including your spouse and/or dependent children). You will pay the premium and the service fee required for coverage directly to Wellmark.

Office Services received from an Alliance Select Provider

Under our Blue Priority HSA/Alliance Select Qualified high-deductible PPO health plans, you are required to pay the deductible and applicable coinsurance amounts for covered office services performed by an Alliance Select network provider.

These office services include office visits and consultations, x-rays, laboratory testing, and minor surgery; and most outpatient x-rays and laboratory testing billed by an Alliance Select participating facility when your practitioner refers you to the facility.

Office Services received from a Non-Alliance Select Network Provider

For covered office services received by a non-Alliance Select network provider, you are responsible for your deductible and coinsurance amount. If you visit a non-Alliance Select network provider’s office, you may have to pay more out-of-pocket.

Plan Comparison Chart

The deductible amount may change each year in accordance with the Federal government's cost-of-living adjustments for high deductible health plans that qualify to accompany a Health Savings Account. This adjustment will be made whether or not you participate in a Blue Priority HSA plan. **The Blue Priority HSA/Alliance Select Qualified High-Deductible PPO health plans featured in this outline of coverage have varying benefits. You may select one of the plans below:**

Plan Name	Blue Priority HSA/Alliance Select Qualified High-Deductible PPO Plans				
	1750A	2850A	5500A	1750B	2850B
Benefit Period Medical Deductible (S/F) ¹	\$1,750/\$3,500, Coordinates with drug deductible ²	\$2,850/\$5,700, Coordinates with drug deductible ²	\$5,500/\$11,000, Coordinates with drug deductible ²	\$1,750/\$3,500, Coordinates with drug deductible ²	\$2,850/\$5,700, Coordinates with drug deductible ²
Coinsurance — You Pay					
Alliance Select Provider	0%			20%	
Non-Alliance Select Provider	40%			40%	
Benefit Period Out-of-Pocket Maximum ³ (S/F) ¹					
Alliance Select Provider	\$1,750/\$3,500	\$2,850/\$5,700	\$5,500/\$11,000	\$3,750/\$7,500	\$4,850/\$9,700
Non-Alliance Select Provider	\$3,750/\$7,500	\$4,850/\$9,700	\$7,500/\$15,000	\$5,750/\$11,500	\$6,850/\$13,700
Office Services	Deductible and coinsurance apply			Deductible and coinsurance apply	
Emergency Room	Deductible and coinsurance apply			Deductible and coinsurance apply	
Prescription Drugs — Blue Rx Preferred ⁴					
Drug Deductible (S/F) ¹	\$1,750/\$3,500, Coordinates with medical deductible ²	\$2,850/\$5,700, Coordinates with medical deductible ²	\$5,500/\$11,000, Coordinates with medical deductible ²	\$1,750/\$3,500, Coordinates with medical deductible ²	\$2,850/\$5,700, Coordinates with medical deductible ²
Tier 1 (generics)	After deductible, plan pays 100% of covered drugs			After deductible, you pay a \$5 copayment	
Tier 2 (preferred brand name)	After deductible, plan pays 100% of covered drugs			After deductible, you pay a \$35 copayment	
Tier 3 (non-preferred brand name)	After deductible, plan pays 100% of covered drugs			After deductible, you pay greater of \$50 or 50%	
Specialty Self-Administered Drugs	After deductible, plan pays 100% of covered drugs			After deductible, you pay a \$85 copayment	
Preventive Care (including well-child care up to age 7)					
Alliance Select Providers	Covered. Deductible waived.			Covered. Deductible and coinsurance waived.	
Non-Alliance Select Providers	Covered. Deductible and coinsurance apply.			Covered. Deductible and coinsurance apply.	
Chiropractic Care	Covered			Covered	
Mental Health and Chemical Dependency Treatment	Not covered			Not covered	
Contraceptives	Covered			Covered	
BlueCard® (Out-of-State) Coverage	Yes			Yes	
Maternity Coverage (Optional)	Complications only. Optional maternity benefit is available. ⁵				
Dental Coverage (Optional)	Available			Available	

¹ (S/F) — 'S' stands for single; 'F' stands for family; The family deductible can be met through any combination of family members. The entire family deductible amount must be met before benefits are payable.

² Amounts paid toward covered medical services or prescription drugs apply toward the benefit period medical deductible and out-of-pocket maximum.

³ Out-of-pocket amounts you pay for Alliance Select or non-Alliance Select covered services apply to both the Alliance Select and non-Alliance Select out-of-pocket maximums.

⁴ Routine immunizations waive deductible, copayments, and/or coinsurance when using the Blue Rx Preferred drug card.

⁵ If you choose the optional maternity coverage on your application, coverage for maternity services (except for complications of pregnancy) will be subject to an exclusion period of 12 months.

Benefits

Approved Hospital/Health Care Facility Services

Blue Priority HSA/Alliance Select Qualified health plans provide medically necessary services and supplies related to the treatment of an illness or injury as an inpatient in a facility.

Approved health care facilities include ambulatory surgical facilities, hospitals, and nursing facilities.

Note: Even though a facility may participate with the Alliance Select network, other providers within the facility, such as emergency room practitioners, anesthesiologists, home medical equipment suppliers, and others may not participate with the Alliance Select network. It is very important to ask if the provider participates in the Alliance Select network before you receive covered services.

Inpatient Services

All Blue Priority HSA/Alliance Select Qualified plans cover:

- Accidental injury care
- Anesthetics and their administration
- Blood administration
- Chemotherapy services
- Complications of pregnancy
- Corneal grafts
- Dietary services
- Dressing and casts
- Drugs and biologicals
- Emergency care
- General nursing care
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical and surgical supplies
- Occupational therapy to treat the upper extremities
- Physical therapy
- Rehabilitative speech therapy treatment (must be coordinated through home health services if provided through a home health agency)
- Room and meals, including private rooms when medically necessary
- Special care units, including burn, intensive, and cardiac care units

Outpatient Services

All Blue Priority HSA/Alliance Select Qualified plans cover:

- Accidental injury care
- Anesthetics and their administration
- Chemotherapy services
- Complications of pregnancy
- Corneal grafts
- Dressing and casts
- Drugs and biologicals
- Emergency care
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical and surgical supplies
- Occupational therapy to treat the upper extremities
- Physical therapy
- Rehabilitative speech therapy treatment (must be coordinated through home health services if provided through a home health agency)
- Room and meals, including private rooms when medically necessary
- Special care units, including burn, intensive, and cardiac care units

Approved Practitioner Services

Approved practitioners include: advanced registered nurse practitioners, audiologists, chiropractors, dentists, doctors of osteopathy, medical doctors, occupational therapists, optometrists, oral surgeons, physical therapists, physician assistants, podiatrists, and speech pathologists.

The following is a list of approved practitioner services for all plans:

- Accidental injury services
- Allergy testing and treatment
- Anesthetics and their administration
- Assisting surgeon services
- Certain dental services
- Chemotherapy
- Complications of pregnancy
- Concurrent care
- Consultation services
- Corneal grafts
- Emergency care
- Genetic testing and genetic counseling in certain circumstances
- Hemodialysis services
- Medical services — other than surgical or obstetrical
- Musculoskeletal Treatment
- Occupational therapy to treat the upper extremities
- Physical therapy
- Preventive care, including:
 - One routine gynecological examination per member per benefit period
 - One routine mammography x-ray per member per benefit period. (Mammograms may be more frequent if recommended by your practitioner.)
 - One routine physical examination and related services per member per benefit period
 - Routine immunizations
 - Routine pap smears
 - Well-child care including physical exams, immunizations and laboratory services until the child reaches age 7.
- Radiation therapy
- Rehabilitative speech therapy treatment (must be coordinated through home health services if provided through a home health agency)
- Surgical services
- X-ray and laboratory services including electrocardiograms and ultrasound

Organ Transplant Coverage

Coverage is available under all Blue Priority HSA/Alliance Select Qualified plans for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, and liver and for certain autologous and allogenic bone marrow/stem cell transfer transplants.

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

Other Covered Services for All Plans

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

- is a child under age 14 who, based on a determination by a licensed dentist and the child's treating practitioner, has a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
- has, based on a determination by a licensed dentist and the member's treating practitioner, one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.

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

- Ambulance services (professional air or ground)
- Contraceptive devices requiring a prescription
- Home infusion therapy
- Home medical equipment, including wheelchairs and hospital beds that are purchased or rented
- Home skilled nursing, limited to 100 visits for a member in a benefit period, if given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager
- Oxygen and equipment
- Prosthetic appliances

Continued on next page

Maternity Coverage

A \$2500 optional maternity deductible level is available. If you choose the optional maternity coverage on your application, you have coverage for routine maternity services normally associated with pregnancy, including prenatal and postnatal care and delivery, subject to a 12-month exclusion period. Once the maternity deductible is met, you pay 50% coinsurance. The deductible for the maternity option is separate from and does not apply to the plan deductible. The deductible and coinsurance specific to maternity do not apply to the plan out-of-pocket maximum and continue after the plan out-of-pocket maximum is met and do not apply to complications of pregnancy. If you choose the optional maternity coverage on your application, coverage for routine maternity services (except for complications of pregnancy) is subject to an exclusion period of 12 months. The optional maternity benefit provides coverage for routine maternity services normally associated with pregnancy, including prenatal and postnatal care and delivery, only after 12 consecutive months of coverage, beginning on the effective date of maternity coverage. Routine maternity services normally associated with pregnancy, including prenatal and postnatal care and delivery, that occur during the 12-month exclusion period will not be covered unless such services are the result of a complication of pregnancy.

Home Health Services

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

All plans include these covered services and supplies

- Home health aide services
- Inhalation therapy
- Medical equipment and supplies
- Medical social services
- Most prescription drugs and medicines
- Occupational therapy to treat the upper extremities and physical therapy
- Oxygen and equipment
- Parenteral and enteral nutrition
- Prosthetic appliances and braces
- Home skilled nursing visits, limited to 100 visits for a member in a benefit period, if given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager.
- Rehabilitative speech therapy treatment provided through a home health agency must be coordinated through home health services. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.

Hospice Services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include the same services as described under home health services as well as respite care from a facility approved by Medicare or JCAHO. Respite care offers rest and relief help for the family caring for a terminally ill patient.

Limitations

Your Blue Priority HSA/Alliance Select Qualified coverage is limited as follows:

Pre-Existing Condition Exclusion Period

Anyone listed on the application who is 19 or older will have an exclusion period of 365 days from the date your certificate begins for all pre-existing conditions. However, the exclusion period for pre-existing conditions is waived if:

- You have qualifying previous coverage as defined in your certificate, and
- Your qualifying previous coverage was continuous within 63 days prior to the date when your new coverage began.

The pre-existing exclusion period will be waived for individuals under age 19.

Note: These plans are medically underwritten. When you apply for one of these plans, we will do one of the following:

- Approve coverage; or
- Offer coverage at a substandard (higher) premium; or
- Deny coverage (Individuals under 19, listed on the application, will not be denied coverage).

Wellmark will only accept child only applications during the annual open enrollment period.

Cosmetic Surgery

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

Breast Reconstruction After a Mastectomy

If you have a mastectomy and elect breast reconstruction in connection with the mastectomy, you are covered for the following:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy.

Home Skilled Nursing/Nursing Facilities

- Number of days in a nursing facility is limited to 90 days per person per benefit period.
- Home skilled nursing is limited to 100 visits per person per benefit period.

Respite Care

Benefits for respite care are limited to a lifetime maximum of 15 days for inpatient and 15 days for outpatient care. Benefits must be used in increments of five days or less.

Weight-Reduction Surgery

You are covered for weight reduction surgery provided you meet eligibility criteria for age, medical condition, and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. If you are accepted and issued coverage, you will receive a benefits certificate detailing how to submit a request for prior approval. For information on the requirements to qualify for surgery, visit www.wellmark.com/WRS.

Exclusions

The following services are excluded or are not considered medically necessary by Wellmark Blue Cross and Blue Shield of Iowa and will not be covered in these Blue Priority HSA/Alliance Select Qualified certificates:

Counseling

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Bereavement counseling or services
- Certain developmental and learning disorders
- Certain disorders of early childhood (such as academic underachievement disorder)
- Communication disorders (such as stuttering and stammering)
- Impotence, except as the result of a physical illness or injury
- Impulse-control disorders (such as pathological gambling)
- Marriage and family counseling
- Mental Health and Chemical Dependency treatment
- Nicotine dependence
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders (including sex-change surgery)

Fertility, Infertility and Maternity

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Abortion
- Infertility treatment
- Maternity (except for complications of pregnancy, or if the optional maternity benefit is purchased). The optional maternity benefit is subject to an exclusion period of 12 months.
- Services provided for the collection of donor semen, oocytes, or the services of a surrogate parent
- Sterilization and sterilization reversal

Miscellaneous

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Anesthesia, local or topical when not billed with a surgical procedure, except anesthesia related to the provision of certain dental services as specified and limited in the certificate
- Arch supports
- Blood, purchase of
- Complications of a non-covered procedure (except pregnancy)
- Dental services except as specified and limited in the certificate
- Elastic stockings and bandages
- Hearing aids and exams
- Investigational treatment
- Maxillary and mandibular implants
- Motor vehicle special equipment
- Non-medical services
- Personal convenience items
- Services furnished to you prior to the date your certificate begins
- Temporomandibular Joint Syndrome
- Travel or lodging costs
- Vision care
- Wigs

Organ Transplants

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Expenses for purchase of any organ
- Mechanical or non-human organs
- Transplant services or supplies other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/stem cell transfers
- Transportation of a living organ donor

Provider Types

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Athletic Trainer
- Community mental health centers
- Facilities for the treatment of chemical dependency
- Licensed independent social workers
- Provider, if an immediate family member
- Psychologists

Covered by Other Programs or Laws

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Military-related injury
- Services and supplies that are covered or could have been covered under Workers' Compensation, including any services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.
- Services and supplies when you are entitled to claim benefits for governmental programs (except Medicaid)
- Services or supplies when someone else has the legal obligation to pay for your care

Therapy, Self-Motivation, and other Programs

All Blue Priority HSA/Alliance Select Qualified plans exclude coverage for:

- Acupuncture
- Cosmetic services and supplies
- Custodial or sanitarium care or rest cares
- Educational or recreational therapy
- Massage therapy
- Occupational therapy supplies
- Rehabilitative speech therapy that is not coordinated through a home health services when services are received through a home health agency. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering
- Self-help or self-cure programs
- Services and supplies as an inpatient provided primarily for diagnostic evaluation, physical therapy, or occupational therapy
- Weight-reduction programs

Additional Exclusions

- Routine foot care
- Routine periodic physical or health examinations, immunizations or screening procedures that are performed solely for school, sport, employment, insurance, licensing, or travel

BlueRx PreferredSM Drug Coverage

Most prescription drugs are covered under Blue Rx Preferred, your managed drug program, not under your health certificate. Wellmark has contracted with Catalyst Rx,[®] a full-service pharmacy benefit management company that provides integrated pharmacy benefit services to customers nationwide, to be our pharmacy benefit manager.

Catalyst Rx offers nationwide access to its fully-integrated pharmacy benefit program. Wellmark members who have their prescriptions filled by any of the more than 63,000 participating pharmacies nationwide¹ — whether in or out-of-state — will have their claims filed electronically by the pharmacy. In addition, network pharmacies have point-of-sale computer access to current information to screen for duplicate therapies or interactions with drugs dispensed by other network pharmacies.

Blue Rx Preferred Prescription Drug Card Plan

Blue Rx Preferred is the name of your prescription drug plan. When filling a prescription, it is important to show your Wellmark ID card to confirm that the pharmacy participates in the Catalyst Rx network that supports Blue Rx Preferred. The Rx BIN number is on your Wellmark ID card.

The pharmacist uses this Rx BIN number to file your claim electronically and to determine how much you pay when picking up your prescription. If you choose to get a prescription from a pharmacy that does not contract with Catalyst Rx, you will need to submit a paper claim to Catalyst Rx in order to receive reimbursement, and you will be responsible for any difference between the Catalyst Rx-negotiated price and the pharmacy's billed charge plus any copayment or coinsurance amount.

Deductible and Out-of-Pocket Maximum Coordination

Under the Blue Priority HSA/Alliance Select Qualified PPO health plans, amounts you pay for covered health services or prescription drugs apply toward the benefit period deductible and out-of-pocket maximum. Even after the deductible is met, you may be responsible for coinsurance or copayments for covered health services and prescription drugs.

Understanding Drug Tiers

Drugs are categorized into tiers according to whether they are generic (Tier 1) or brand name (Tier 2 or Tier 3) drugs.

¹ Catalyst Rx, August 2010

Four Levels of Payment

Under the Blue Priority HSA/Alliance Select Qualified health plans you have a three-tier Blue Rx Preferred plan. With a three-tier Blue Rx Preferred plan, the amount you pay for prescriptions depends on whether the drug is on the first, second or third tier of the Wellmark Drug List.

- You'll have the lowest copayment for drugs on the first tier, Tier 1 (generic drugs).
- You'll have an intermediate copayment for drugs on the second tier, Tier 2 (preferred brand name drugs).
- You'll have the highest copayment for drugs on the third tier, Tier 3 (non-preferred brand name drugs).
- In addition to the three tier structure, you may have a specialty drug copayment for specialty self-administered drugs.

Covered Drugs

- Drugs dispensed by a pharmacist from a licensed retail pharmacy including routine immunizations and the administration of routine immunizations.
- Insulin and insulin-related supplies such as needles, syringes, test strips, and lancets.
- Most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," including contraceptives.
- Prescription drugs that are prescribed by a practitioner legally authorized to prescribe.
- Specialty self-administered drugs.

Non-Covered Drugs and Services

- Cosmetic drugs
- Drugs determined to be abused or otherwise misused by you
- Growth hormones
- Impotence, except as the result of a physical illness or injury
- Investigational drugs
- Irrigation solutions and supplies
- Most nutritional supplements
- Most over-the-counter products, including nutritional dietary supplements; however, certain over-the-counter products prescribed by a physician may be covered as determined by Wellmark
- Self-help or self-cure programs

- Smoking cessation drugs
- Therapeutic devices or medical appliances
- Weight-reduction drugs

Quantity Limitations

Drugs covered under your benefits certificate may be limited per month, benefit period, or lifetime by specific quantity limitations. These limitations are determined by Wellmark based on medical necessity. For a list of drugs subject to quantity limitations, or to determine whether a drug you are taking is subject to prior authorization, visit our website at www.wellmark.com or check with your pharmacist or practitioner.

Generic Drugs

Your copayment may be lower when you purchase Tier 1 generic drugs. If you purchase a brand-name drug when an FDA-approved Tier 1 generic is appropriate and available, you are responsible for the copayment or coinsurance plus the difference between the maximum allowable fee amount for the brand-name drug and the maximum allowable fee amount for the generic drug. This is true even if your practitioner prescribes the brand-name drug.

Retail Prescription Drugs

You are covered for a 30-day supply

Mail-Order Prescription Drugs

You are covered for up to a 90-day supply of maintenance drugs through Wellmark's contracted mail order vendor.

Refills

You may not receive benefits for a refill if sufficient time has not elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner. You may also be denied benefits for a refill under certain other circumstances. Consult your Blue Rx Preferred benefits certificate for a complete list.

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time. If traveling within the United States, the refill amount will be subject to any applicable quantity limits under your Blue Rx Preferred benefits certificate (see the Summary of Payment section). If traveling outside the United States, the refill amount will not exceed a 90-day supply.

Wellmark Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List is a list of safe and cost-effective medications that serves as a guide to practitioners when deciding which medications to prescribe for their patients. The Wellmark Drug List was developed by a local committee of practitioners and pharmacists in cooperation with our contracted pharmacy benefit manager. The list suggests medications a practitioner might prescribe when there is a choice of medications to treat the same condition. This list is continually revised to reflect changes in the drug industry. Practitioners are not limited to prescribing only the drugs that appear on the Wellmark Drug List. Practitioners may prescribe any medication, and that medication will be covered unless it is specifically excluded from your benefits certificate.

Depending upon your plan, however, your copayment may be higher for drugs that are listed on the second or third tier.

Rebates

Using the Wellmark Drug List helps manage the overall cost of prescription medications by promoting the use of more cost-effective drugs. Drug manufacturers sometimes offer rebates to pharmacy benefit managers based on the inclusion of their drugs on the drug list and associated utilization. We expect to receive rebates from our contracted pharmacy benefit manager. The rebates we receive as a result of your prescription claims processed by our pharmacy benefit manager will be retained by Wellmark Blue Cross and Blue Shield of Iowa and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific claims, and they will not be considered when determining your benefit-period deductible, copayment, or coinsurance amount.

Prior Authorization

Certain drugs listed on the Wellmark Drug List are covered by your benefits certificate only with prior authorization. Prior authorization allows us to verify that the drug is medically necessary and part of a specific treatment plan. Your practitioner must call us to obtain prior authorization.

You have the right to one full and fair review in case of an adverse decision in response to a prior authorization request. An adverse decision is one that denies or reduces benefits. You (or your authorized representative, if you have designated one) may appeal an adverse decision.

BlueDentalSM Coverage

Dental coverage is available through the Blue Dental Program. This optional coverage offers benefits for diagnostic and preventive care, minor restorative care, and major restorative care.

When you first apply for one of our Blue Priority/HSA Alliance Select Qualified high-deductible PPO health plans, you will have the opportunity to choose Blue Dental coverage. If you do not accept Blue Dental at this time, you can add it at anytime. Following our acceptance of your application and issuance to you of the Blue Priority HSA/Alliance Select Qualified and Blue Dental certificates, if you decide to terminate the certificates, you will not be eligible for a medical certificate with the same deductible. You may apply for a medical certificate with a different deductible amount, subject to our applicable medical underwriting guidelines.

Blue Dental Network

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

Dental Health Alliance (DHA) Network

If you reside or travel outside the Blue Dental service area, you can visit a dentist who is part of the national DHA network. The DHA network includes more than 92,500 locations through DHA.¹ Just show your ID card to the DHA dentist to receive the same advantages you receive when visiting a Blue Dental provider.

Covered Services

Check-ups and Teeth Cleaning

- Bitewing x-rays — once every 12 consecutive months
- Dental cleaning/prophylaxis — twice per benefit period
- Full-mouth x-rays — once every five consecutive years
- Occlusal and extraoral x-rays
- Oral evaluations — twice per benefit period
- Periapical x-rays
- Space maintainers — only for dependent children under age 15
- Topical fluoride applications — for dependent children under the age of 19, once every 12 consecutive months

- Topical sealant applications —for eligible dependent children under age 15; once per permanent first and second molars in a lifetime

Cavity Repair and Tooth Extractions

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

Major Restorative

- Endodontics
- Periodontics
- Crowns
- Onlays and Inlays

Exclusions

- Bridges
- Congenital deformities
- Cosmetic procedures
- Dentures
- Implants
- Local anesthesia when billed separately
- Orthodontics
- Occlusal adjustment

¹ Dental Health Alliance, 2010

	Your Payment Options
Benefit Period Deductible (Applies to all services except diagnostic and preventive)	\$50 Single/\$100 Two-person/\$150 Family
Benefit Period Maximum	\$1,000 per person covered
Diagnostic & Preventive	20% coinsurance
Basic Restorative: Fillings, extractions, oral surgery (6-month waiting period before benefits are available)	20% coinsurance
Major Restorative: Endodontics, periodontics, crowns, onlays and inlays (12-month waiting period before benefits are available)	50% coinsurance
Bridges and Dentures	Not covered

BlueCard® Program (Out-Of-State Coverage)

This program, offered by all Blue Cross and Blue Shield Plans around the world, gives you a simple means to save money — no matter where you live or travel in the United States and numerous other countries. When you need medical attention, all you have to do is show your ID card to a provider who participates with the local Blues Plan.

When you use a BlueCard PPO provider:

- You pay the applicable deductible, copayment or coinsurance amount.
- You'll get Blue Plan PPO-provider negotiated prices.
- Your claims will be processed at the Alliance Select in-network coinsurance level.
- Participating providers have agreed not to collect from you any difference between their billed charge and the negotiated charge.
- Access to more than 630,000 physicians and 6,500 hospitals worldwide.¹
- Participating providers and many non-participating providers will honor your ID card and file your claims for you.

BlueCard providers do not handle notification requirements for you.

Notification Requirements

The following are notification requirements you or your Alliance Select network provider should follow to receive the maximum benefits available under your certificate.

Precertification

Precertification is a process whereby you or your provider notify Wellmark Blue Cross and Blue Shield of Iowa before a planned admission to a nursing facility, or acute rehabilitation facility. Precertification is also required before receiving home health, hospice, home infusion therapy, or home skilled nursing services. During precertification, Wellmark Blue Cross and Blue Shield of Iowa checks benefit eligibility and determines whether medical necessity standards have been met.

Continued Stay Review

Continued Stay Review is a review of your care when you are in a hospital, nursing facility, or other health facility or when you use home health services, hospice services, or home infusion therapy. Wellmark Blue Cross and Blue Shield of Iowa will initiate the review. If it is determined your current level of care is no longer medically necessary, we will notify you, your attending practitioner and the facility 24 hours before your benefits for services end.

Note: We will notify you of the date when coverage for services ends. We will not provide benefits for services received after this date.

Prior Approval

Before you receive treatment for certain services, supplies, or procedures, we recommend you or your provider request our prior approval. Prior approval helps determine whether a proposed treatment plan is medically necessary, a benefit of your certificate, and ensures you receive full benefits for certain services.

A list of services for which we recommend prior approval can be found in your certificate.

¹ Blue Cross and Blue Shield Association, 2010

General Provisions

Eligibility: You are eligible to apply for Blue Priority HSA/Alliance Select Qualified coverage if you are a resident of Iowa, under 65 years of age, a Farm Bureau Federation member in Iowa and not eligible for Medicare. If you become enrolled in Medicare during the term of this benefits certificate, this benefits certificate will provide benefits secondary to Medicare unless application of federal law determines this benefits certificate must provide benefits primary to Medicare. If you are applying for child-only coverage, the child(ren) is eligible for coverage during the annual open enrollment period or due to a qualifying event.

Coverage Renewability

- Coverage is automatically renewed by payment of your premium and service fee in advance.
- We may terminate your certificate if: (1) you fail to pay your premium and service fee when due; or (2) there is fraudulent use of your certificate; or (3) you fail to maintain your Iowa Farm Bureau membership.
- When you no longer qualify as a dependent or spouse under this certificate, you may obtain coverage from Wellmark Blue Cross and Blue Shield of Iowa with no additional underwriting if you apply for a plan with equal or lesser benefits within 31 days of the date you become ineligible and you are a Farm Bureau Federation member in Iowa.

Medicare Eligibility

When you become eligible for Medicare, you may convert to one of our Medicare supplement plans without answering health questions if you still reside in Iowa, and you have Medicare Parts A and B, and you apply during your six-month guaranteed enrollment period. This period begins with the first month that you are both age 65 or older and enrolled in Medicare Part B (medical insurance).

Medicare Enrollment

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

Subrogation

Once you receive benefits under your Blue Priority HSA/Alliance Select Qualified certificate arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to that illness or injury. We will assume all rights for recovery, to the extent of our payment, regardless of whether our payment is made before or after settlement of any third-party claim,

and regardless of whether you have received full or complete compensation for any injury or illness. You and your covered family member(s) agree to notify us if you have the potential right to receive payment from someone else and to cooperate with us to ensure that our rights to subrogation are protected. We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

Coordination of Benefits

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

Benefits payable under this certificate, when combined with those paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount. The method we use to calculate the payment arrangement amount may be different from your other plan's method.

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

Other Information

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

Health and Wellness Programs

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

Personal Health Assistant 24/7

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

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

Pregnancy Care Program

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

Complex Case Management Program

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

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

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

If You Have Questions or Need Additional Information:

Please call your local Farm Bureau agent

GET THE BEST OF BOTH



Products available at Farm Bureau Financial Services

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