



Wellmark Blue Cross and Blue Shield of South Dakota is an
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C O V E R A G E M A N U A L

BlueSelect[®] **Blue Rx CompleteSM** **Brandon Valley School District PPO**

Form Number: Wellmark SD Grp

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NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy.

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(please turn to back of page)

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than \$300,000 in death benefits and not more than \$100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than \$500,000 for basic hospital, medical and surgical insurance, not more than \$300,000 for disability insurance and long term care insurance, and not more than \$100,000 for other types of health insurance; and (iii) for annuities, not more than \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of \$300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed \$500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dir.sd.gov/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

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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.

This group health plan consists of medical benefits and prescription drug benefits. The medical benefits are called Blue Select. The prescription drug benefits are called Blue Rx Complete. This coverage manual will indicate when the service, supply, or drug is considered medical benefits or drug benefits by using sections, headings, and notes when necessary.

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 call the Customer Service number on your ID card.

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.

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 PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

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

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

Out-of-Network Providers. Out-of-Network Providers do not participate with Wellmark or any other Blue Cross and/or Blue Shield Plan. You typically pay the most for services from these providers.

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.

Medical	
You Pay	
Deductible	
\$1,000 per person for covered services received from PPO Providers.	
\$2,000 (maximum) per family* for covered services received from PPO Providers.	
\$2,500 per person for covered services received from Participating and Out-of-Network providers.**	
\$5,000 (maximum) per family* for covered services received from Participating and Out-of-Network providers.**	
Emergency Room Copayment	
\$150	
Office Visit Copayment	
\$20 for covered services received from PPO Providers.	
Telehealth Services Copayment	
\$20 for covered telehealth services received from practitioners contracting through Doctor on Demand®.	
\$20 for covered telehealth services received from PPO Providers.	

You Pay**Urgent Care Center Copayment**

\$20 for covered services received from PPO Providers in South Dakota or Iowa classified by Wellmark as Urgent Care Centers and covered urgent care services received from PPO urgent care facilities or clinics outside of South Dakota or Iowa.†

Coinsurance

20% for covered services received from PPO Providers.

40% for covered services received from Participating and Out-of-Network providers.**

Out-of-Pocket Maximum

\$2,000 per person for covered services received from PPO Providers.

\$4,000 (maximum) per family* for covered services received from PPO Providers.

\$5,000 per person for covered services received from Participating and Out-of-Network providers.**

\$10,000 (maximum) per family* for covered services received from Participating and Out-of-Network Providers.**

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

**Participating and Out-of-Network providers are non-PPO. See *Choosing a Provider*, page 37.

†For a list of South Dakota or Iowa facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.

§Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application.

Prescription Drugs

You Pay†**Deductible**

\$50 per person

\$100 (maximum) per family*

Copayment

\$10 for Tier 1 medications.

\$25 for Tier 2 medications.

\$40 for Tier 3 and 4 medications.

For more information see *Tiers*, page 57.

\$100 for preferred specialty drugs.

Coinsurance

50% for non-preferred specialty drugs.

Out-of-Pocket Maximum

\$2,000 per person

\$4,000 (maximum) per family*

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

†You pay the entire cost if you purchase a drug that is not on the Wellmark Blue Rx Complete Drug List. See Wellmark Blue Rx Complete Drug List, page 30.

Prescription Maximums

Generally, there is a maximum days' supply of medication you may receive in a single prescription. However, exceptions may be made for certain prescriptions packaged in a dose exceeding the maximum days' supply covered under your Blue Rx Complete prescription drug benefits. To determine if this exception applies to your prescription, call the Customer Service number on your ID card.

Your payment obligations may be determined by the quantity of medication you purchase.

Payment**90 day retail**

Payment per days' supply:

- 1 copayment for 30 day supply
- 2 copayments for 60 day supply
- 3 copayments for 90 day supply

90 day mail order

Payment per days' supply:

- 1 copayment for 30 day supply
- 2 copayments for 60 day supply
- 3 copayments for 90 day supply

30 day specialty

- 1 copayment or coinsurance, as applicable

Payment Details**Medical****Deductible**

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

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

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

Once you meet the deductible, then coinsurance applies.

Deductible amounts you pay during the last three months of a benefit year carry over as credits to meet your deductible for the next benefit year. These credits do not apply toward your out-of-pocket maximum.

Common Accident Deductible. When two or more covered family members are involved in the same accident and they receive covered services for injuries related to the accident, only one deductible amount will be applied to the accident-related services for all family members involved. However, you still need to satisfy the family

(not the per person) out-of-pocket maximum.

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

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 covered office services received from PPO practitioners and to PPO independent labs. Laboratory services performed by a separate PPO lab or practitioner are subject to a separate office visit copayment. Separate facility services are subject to deductible and coinsurance.
- is taken once per practitioner per date of service.

Telehealth Services Copayment.

The telehealth services copayment:

- applies to covered telehealth services received from PPO practitioners and practitioners contracting through Doctor on Demand.
- is taken once per practitioner per date of service.

Urgent Care Center Copayment.

The urgent care center copayment:

- applies to covered urgent care services received from:
 - PPO Providers in South Dakota or Iowa classified by Wellmark as Urgent Care Centers.
 - PPO urgent care facilities or clinics outside of South Dakota or Iowa.
- is taken once per provider per date of service.

Please note: If you receive care at a facility in South Dakota or 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.

Coinsurance

Coinsurance is an amount you pay for certain covered services. Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance*

is Calculated, page 53. Coinsurance amounts apply after you meet the deductible.

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

Out-of-Pocket Maximum

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

- Deductible.
- Coinsurance.

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

Out-of-pocket maximum amounts you pay for PPO, Participating, or Out-of-Network provider services apply toward meeting both the PPO and Participating/Out-of-Network out-of-pocket maximums.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.
- Emergency room copayments.
- Office visit copayments.
- Telehealth services copayments.
- Urgent care center copayments.

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

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 Blue Cross and Blue Shield of South Dakota.

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Independent laboratory services for treatment of mental health conditions and chemical dependency received from PPO Providers.	Deductible Coinsurance Copayment
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services.	Deductible
Office and independent lab services received from PPO Providers. Some lab testing performed in the office may be sent to a provider that is not a PPO Provider for processing. When this happens, your deductible and coinsurance may apply.	Deductible Coinsurance
Postpartum home visit (one) when a mother and her baby are voluntarily discharged from the hospital within 48 hours of normal labor and delivery or within 96 hours of cesarean birth.**	Deductible Coinsurance
Preventive care*** – outpatient services received from PPO Providers.	Deductible
Services subject to emergency room copayment amounts.	Deductible Coinsurance
Services subject to office visit copayment amounts.	Deductible Coinsurance
Services subject to telehealth services copayment amounts.‡	Deductible Coinsurance
Services subject to urgent care center copayment amounts.	Deductible Coinsurance

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

***Digital breast tomosynthesis (3D mammogram) maybe subject to deductible, coinsurance, and copayments, as applicable.

‡ Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application.

Prescription Drugs

Deductible

Deductible is the fixed dollar amount you pay for covered drugs in a benefit year before Blue Rx Complete prescription drug benefits become available.

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

Once you meet the deductible, then the copayment or coinsurance applies.

Coinsurance or Copayment

Coinsurance is the amount you pay, calculated using a fixed percentage of the maximum allowable fee, each time a covered non-preferred specialty drug prescription is filled or refilled. Copayment is a fixed dollar amount you pay each time any other covered prescription is filled or refilled. Coinsurance or copayment amounts apply after you meet the deductible for the benefit year.

You pay the entire cost if you purchase a drug that is not on the Wellmark Blue Rx Complete Drug List. See *Wellmark Blue Rx Complete Drug List*, page 30.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum you pay in a given benefit year toward the following amounts:

- Deductible.
- Coinsurance.
- Copayments.

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

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved “A”-rated medically appropriate generic equivalent.

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

Waived Payment Obligations

Some payment obligations are waived for the following covered drugs or services.

Covered Drug or Service	Payment Obligation Waived
Tier 1 drugs.	Deductible

2. At a Glance - Covered and Not Covered

Medical

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 Blue Cross and Blue Shield of South Dakota.

Please note: Benefits maximums accumulate for medical and prescription drug benefits separately.

Category	Covered	Not Covered	See Page	Benefits Maximums
Acupuncture Treatment		⊘	13	
Alcoholism Treatment	●		13	
Allergy Testing and Treatment	●		13	
Ambulance Services	●		13	
Anesthesia	●		14	

Category	Covered	Not Covered	See Page	Benefits Maximums
Autism Treatment	●		14	Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorder for children age 18 and younger: <ul style="list-style-type: none"> ■ For children through age six: \$36,000 per calendar year. ■ For children age seven through age 13: \$25,000 per calendar year. ■ For children age 14 through age 18: \$12,500 per calendar year.
Blood and Blood Administration	●		15	
Blood Pressure Monitoring		⊙	15	
Chemical Dependency Treatment	●		15	
Chemotherapy and Radiation Therapy	●		15	
Contraceptives		⊙	15	
Cosmetic Services		⊙	15	
Counseling and Education Services		⊙	16	
Dental Treatment for Accidental Injury	●		16	
Dialysis	●		16	
Education Services for Diabetes	●		17	Two diabetic education programs per lifetime. Eight visits per benefit year for follow-up training.
Emergency Services	●		17	
Fertility Services	●		17	
Genetic Testing	●		17	
Hearing Services (related to an illness or injury)	●		17	
Home Health Services	●		18	The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment	●		19	
Hospice Services	●		19	15 days per lifetime for inpatient hospice respite care. 15 days per lifetime for outpatient hospice respite care. Please note: Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		19	90 days per benefit year for skilled nursing services in a hospital or nursing facility.
Illness or Injury Services	●		20	
Infertility Treatment		⊙	20	
Inhalation Therapy	●		20	
Maternity Services	●		20	

Category	Covered	Not Covered	See Page	Benefits Maximums
Medical and Surgical Supplies and Personal Convenience Items	●		21	
Mental Health Services	●		22	
Morbid Obesity Treatment	●		23	
Motor Vehicles		⊖	23	
Musculoskeletal Treatment	●		23	
Nonmedical or Administrative Services		⊖	23	
Nutritional and Dietary Supplements	●		23	
Occupational Therapy	●		23	
Orthotics		⊖	24	
Physical Therapy	●		24	
Physicians and Practitioners			24	
Advanced Registered Nurse Practitioners	●		24	
Audiologists	●		24	
Certified Registered Nurse Anesthetists	●		24	
Chiropractors	●		24	
Dentists—but not for general dentistry	●		24	
Doctors of Osteopathy	●		24	
Licensed ABA Therapists	●		24	
Licensed Independent Social Workers	●		24	
Medical Doctors	●		24	
Nurse Practitioners and Midwives	●		24	
Occupational Therapists	●		25	
Optometrists	●		25	
Oral Surgeons	●		25	
Physical Therapists	●		25	
Physician Assistants	●		25	
Podiatrists	●		25	
Psychologists	●		25	
Qualified Mental Health Professionals	●		25	
Speech Pathologists	●		25	
Prescription Drugs	●		25	

Category	Covered	Not Covered	See Page	Benefits Maximums
Preventive Care	●		26	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year. One diagnostic screening for prostate cancer, including digital rectal examination and prostate-specific antigen (PSA) test, for: <ul style="list-style-type: none"> ■ Asymptomatic men aged 50 and older; ■ Men 45 and older who are at a high risk for prostate cancer.
Prosthetic Devices	●		27	
Reconstructive Surgery	●		27	
Self-Help Programs		⊙	27	
Sleep Apnea Treatment	●		27	
Social Adjustment		⊙	28	
Speech Therapy	●		28	
Surgery	●		28	
Telehealth Services	●		28	
Temporomandibular Joint Disorder (TMD)	●		28	
Transplants	●		28	
Travel or Lodging Costs		⊙	29	
Vision Services (related to an illness or injury)	●		29	
Wigs or Hairpieces		⊙	29	
X-ray and Laboratory Services	●		29	

Prescription Drugs

Please note: To determine if a drug is covered, you must consult the Wellmark Blue Rx Complete Drug List. You are covered for drugs listed on the Wellmark Blue Rx Complete Drug List. If a drug is not on the Wellmark Blue Rx Complete Drug List, it is not covered.

For details on drug coverage, drug limitations, and drug exclusions, see the next section, *Details – Covered and Not Covered*.

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 33. If a service or supply is not specifically listed, do not assume it is covered.

Medical

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Alcoholism Treatment

Covered.

Licensed Substance Abuse Treatment

Program. Benefits are available for alcoholism treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Treatment provided in a medically monitored intensive inpatient or detoxification setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Room and board provided while participating in a clinically managed low

intensity residential treatment setting, also known as supervised living.

- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in substance abuse treatment programs.

See Also:

Chemical Dependency Treatment later in this section.

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 45.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional emergency 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 with adequate facilities to treat your medical condition.
- During transport, your medical condition requires the services that are provided only by an air or ground

ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility in an emergency.

- The air or ground ambulance has the necessary patient care equipment and supplies to meet your needs.
- Your medical condition requires immediate and rapid ambulance transport.
- In addition to the preceding requirements, for air ambulance services to be covered, all of the following must be met:
 - Your medical condition requires immediate and rapid air 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.

In an emergency situation, if you cannot reasonably utilize a PPO ambulance service, covered services will be reimbursed as though they were received from a PPO ambulance service. However, 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.

Not Covered:

- Professional air or ground ambulance transport from a facility capable of treating your condition.
- Non-emergency air or ground transport including, but not limited to, non-emergency air or ground ambulance transportation 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.

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services for the treatment of autism spectrum disorder for children age 18 and younger when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist who has documented training and competence in applied behavior analysis or a licensed behavior analyst. Autism spectrum disorder is a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior.

Benefits Maximum:

- Applied Behavior Analysis services for the treatment of autism spectrum disorder for children age 18 and younger:
 - For children through age six: **\$36,000** per calendar year.
 - For children age seven through age 13: **\$25,000** per calendar year.
 - For children age 14 through age 18: **\$12,500** per calendar year.

Not Covered:

- Applied Behavior Analysis services for the treatment of autism spectrum disorder for members age 19 and older.
- Applied Behavior Analysis services other than for the treatment of autism spectrum disorder.

Blood and Blood Administration

Covered: Whole blood, blood components, blood derivatives, and blood administration.

Please note: Whole blood and blood components are typically made available to you at no charge through the facility from which you receive services.

Blood Pressure Monitoring

Not Covered: Home or ambulatory blood pressure monitoring.

Chemical Dependency Treatment

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

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

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Treatment provided in a medically monitored intensive inpatient or detoxification setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care

general hospital or a medically managed inpatient treatment program.

Not Covered:

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

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 45.

Chemotherapy and Radiation Therapy

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

Contraceptives

Not Covered.

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, marriage counseling or training services, and community-based services.
- Education or educational therapy other than covered education for self-management of diabetes.
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for the treatment of obesity, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia, for any medical, mental health, or substance abuse condition.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes 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.
- Dental treatment for children and disabled persons as follows:
 - Anesthesia and hospital or ambulatory surgical facility charges for dental care, whether services are provided in a hospital, ambulatory surgical facility, or a dental office, for a member who:
 - is under age 14; or
 - if determined by a licensed physician, is severely disabled, has a developmental disability, or otherwise has a medical

condition that places the person at serious medical risk.

- Impacted teeth removal (surgical) as an inpatient or outpatient of a facility 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 associated with management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease of the mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:
 - Dental services related to medical transplant procedures;
 - Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); or
 - Treatment of neoplasms of the mouth and contiguous tissue.

Not Covered:

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

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a

hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes

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

All covered training or education must be prescribed by a licensed physician.

Outpatient training or education must be provided by a qualified diabetes educator and recognized by the American Diabetes Association (ADA) or use a curriculum approved by the ADA or the South Dakota Department of Health.

A diabetes educator is a physician, nurse, dietitian, pharmacist, or other licensed health care provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetes Educators and has completed a course in diabetic education and training or has been certified as a diabetes educator.

Certified diabetic education programs help a person with any type of diabetes and his or her caretaker understand the diabetes disease process and the daily management of diabetes.

Benefits Maximum:

- **Two** certified diabetes education programs per member per lifetime, and
- **Eight visits** per benefit year for follow-up training once you have participated in a diabetes education program.

Emergency Services

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

- Placing the health of the individual or, with respect to a pregnant woman, the

health of the woman and her unborn child, in serious jeopardy; or

- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a PPO Provider, covered services will be reimbursed as though they were received from a PPO Provider.

However, because we do not have contracts with 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 54.

Fertility Services

Covered:

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

Genetic Testing

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

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

Hearing Services

Covered:

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

Not Covered:

- Hearing aids.

- Routine hearing examinations.

Home Health Services

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

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

The following are covered services and supplies:

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

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

- is provided for a definite limited period of time as a safe transition from other levels of care when medically necessary;
- provides teaching to caregivers for ongoing care; or
- provides short-term treatments that can be safely administered in the home setting.

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

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

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

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Not Covered:

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

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

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

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

See Also:

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

Orthotics later in this section.

Prosthetic Devices later in this section.

Hospice Services

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

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

Benefits Maximum:

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

Hospitals and Facilities

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

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

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

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

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

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

Benefits Maximum:

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

Not Covered:

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

See Also:

Alcoholism Treatment earlier in this section.

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illness or Injury Services**Covered:**

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.
- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.

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

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

Not Covered:

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

Infertility Treatment**Not Covered:**

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

Inhalation Therapy

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

Maternity Services

Covered: Prenatal 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.

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

See Also:

Coverage Change Events, page 65.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.

- Diabetic equipment and supplies including insulin syringes purchased from a covered home/durable medical equipment provider.

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

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

air purifiers, humidifiers, or dehumidifiers.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Prescription Drugs, page 29.

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 and other psychotic disorders.
- Bipolar disorders.
- Major depressive disorders.
- Schizo-affective disorders.
- Obsessive-compulsive disorders.

You are also covered for:

- Pervasive developmental disorders.

A mental health condition must satisfy the following criteria:

- 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 in the most current version of *International Classification of Diseases, Clinical Modification* used for diagnosis coding.

Licensed Psychiatric or Mental Health Treatment Program Services. Benefits

are available for mental health treatment in the following settings:

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

Not Covered: Treatment for:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders.
- Medical evaluations, counseling, and any other items or treatment for nicotine dependence.
- Conditions that are not pervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual disorders.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other

activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:

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

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.

Motor Vehicles

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

Musculoskeletal Treatment

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

Not Covered: Massage therapy.

Nonmedical or Administrative Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-

care assessments, health risk assessments, case management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Nutritional and Dietary Supplements

Covered:

- Nutritional and dietary supplements prescribed by a physician for permanent inborn errors of metabolism, such as PKU.
- Enteral and nutritional therapy only when prescribed feeding is administered through a feeding tube, except for permanent inborn errors of metabolism.

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

- Herbal products.
- Fish oil products.
- Medical foods, except as described under *Covered*.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

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:** Orthotics training.**Not Covered:** Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices.**See Also:***Home/Durable Medical Equipment* earlier in this section.*Prosthetic Devices* later in this section.

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

- The goal of the physical therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation 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 and may have a specialty designation such as certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.**Audiologists.****Certified Registered Nurse****Anesthetists.** This provider is a registered nurse who is licensed and certified to administer anesthesia by the Council of Certification of Nurse Anesthetists.**Chiropractors.****Dentists.****Doctors of Osteopathy (D.O.).****Licensed ABA Therapists.****Licensed Independent Social****Workers.** This is a social worker who:

- is licensed under SDCL 36-26-17 (or licensed under a similar statute in another state);
- has had two years of supervised experience in his or her field of specialization; and
- has passed an examination prepared by the Board of Social Work Examiners for this purpose.

Medical Doctors (M.D.).**Nurse Practitioners and Midwives.**

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

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists.

Qualified Mental Health

Professionals. A qualified mental health professional is a physician licensed to practice medicine or osteopathy in South Dakota, or licensed under a similar statute in another state, or is a member of one of the following professions who has received a competency-based endorsement from the Department of Human Services:

- A psychologist licensed to practice psychology in South Dakota (or licensed under a similar statute in another state).
- An advanced practice nurse with at least a master's degree from an accredited education program and either two years or one thousand hours of clinical experience that includes mental health evaluation and treatment.
- A certified social worker with a master's degree from an accredited training program and two years of supervised clinical experience in a mental health setting.
- A person who has a master's degree in psychology from an accredited program and two years of clinical mental health experience and who meets the provision of SDCL 36-27A 2 (2) (or is licensed under a similar statute in another state).
- A counselor licensed under SDCL 36-32 as a professional counselor (or licensed under a similar statute in another state) and has two years of supervised clinical experience in a mental health setting following attainment of a master's degree.
- A therapist licensed under SDCL 36-33 as a marriage and family therapist (or licensed under a similar statute in another state) and has two years of supervised clinical experience in a mental health setting.
- A physician assistant who is licensed under chapter 36-4A and either two years or one thousand hours of clinical experience that includes mental health evaluation and treatment; or
- A professional as listed above who is employed by the federal government and currently licensed in that profession in another state, in good standing with the licensing board, and acting within the scope of the professional's license.

Speech Pathologists.

Not Covered:

- Athletic Trainers.
- Certified Registered Nurses when the C.R.N. is in independent practice and not an employee of a covered provider.

See Also:

Choosing a Provider, page 37.

Prescription Drugs

Covered: Most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," are generally covered under your Blue Rx Complete prescription drug benefits, not under your medical benefits. However, there are exceptions when prescription drugs and medicines are covered under your medical benefits.

Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered. For a list of these drugs,

visit our website at *Wellmark.com* or check with your pharmacist or physician.

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. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Intravenous Administration.

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

Specialty Drugs. Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They are not available through the mail order drug program.

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

Not Covered: Some prescription drugs, services, and items are not covered under either your medical benefits or your Blue Rx Complete benefits. For example:

- Antigen therapy.
- Medication Therapy Management (MTM) when billed separately.
- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that

has an FDA-approved “A”-rated medically appropriate generic equivalent.

- Prescription drugs that are not FDA-approved.

Some prescription drugs are covered under your Blue Rx Complete benefits:

- Insulin.

See the Wellmark Blue Rx Complete Drug List at *Wellmark.com* or call the Customer Service number on your ID card and request a copy of the Drug List.

See Also:

Contraceptives earlier in this section.

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

Notification Requirements and Care Coordination, page 45.

Prescription Drugs later in this section.

Prior Authorization, page 51.

Preventive Care

Covered:

- Preventive screening for prostate cancer, including the related office examination, and prostate-specific antigen test.
- Diagnostic screening for prostate cancer, including diagnostic examination, digital rectal examination, prostate-specific antigen test, and bone scan if medically indicated.
- Physical examinations and related preventive services such as:
 - Digital breast tomosynthesis (3D mammogram).
 - Gynecological examinations.
 - Immunizations.
 - Mammograms.
 - Pap smears.
- Normal newborn care (physician services provided to a baby during the mother’s initial hospitalization).
- Well-child care including immunizations.

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** diagnostic screening for prostate cancer, including digital rectal examination and prostate-specific antigen (PSA) test, for:
 - asymptomatic men aged 50 and older;
 - men 45 and older who are at a high risk for prostate cancer.

This limitation does not apply to men of any age with a history of prostate cancer, who are covered for medically indicated testing at intervals recommended by a physician.

Not Covered:

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

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

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

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

Not Covered:

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

See Also:

Home/Durable Medical Equipment earlier in this section.

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

Orthotics earlier in this section.

Reconstructive Surgery

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

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

Social Adjustment

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

Speech Therapy

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

Not Covered:

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

Surgery

Covered. This includes the following:

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

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

Covered: You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification or by a practitioner contracting through Doctor on Demand via real-time, interactive audio-visual technology or web-based mobile

device or similar electronic-based communication network. Services must be delivered in accordance with applicable law and generally accepted health care practices.

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

Not Covered: Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission.

Temporomandibular Joint Disorder (TMD)

Covered.

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

Transplants

Covered:

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

Transplants are subject to case management.

The medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.

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

and you are a donor, the charges will be covered by your medical benefits.

Not Covered:

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

See Also:

Ambulance Services earlier in this section.

Case Management, page 50.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered:

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

result of cataract extraction or when the underlying diagnosis is a corneal injury or corneal disease.

Not Covered:

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

Wigs or Hairpieces

Not Covered.

X-ray and Laboratory Services

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

See Also:

Preventive Care earlier in this section.

Prescription Drugs

Guidelines for Drug Coverage

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

- Listed on the Wellmark Blue Rx Complete Drug List.
- Can be legally obtained in the United States only with a written prescription.
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962.

- Prescribed by a practitioner prescribing within the scope of his or her license.
- Dispensed by a recognized licensed participating retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program, or through the mail order drug program.
- Medically necessary for your condition. See *Medically Necessary*, page 33.
- Not available in an equivalent over-the-counter strength. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product

is covered, call the Customer Service number on your ID card.

- Reviewed, evaluated, and recommended for addition to the Wellmark Blue Rx Complete Drug List by Wellmark.

Drugs that are Covered

The Wellmark Blue Rx Complete Drug List

The Wellmark Blue Rx Complete Drug List is a reference list that includes generic and brand-name prescription drugs that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Complete prescription drug benefits. The Drug List is updated on a quarterly basis, or when new drugs become available, and as discontinued drugs are removed from the marketplace.

To determine if a drug is covered, you must consult the Wellmark Blue Rx Complete Drug List. You are covered for drugs listed on the Wellmark Blue Rx Complete Drug List. If a drug is not on the Wellmark Blue Rx Complete Drug List, it is not covered.

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, Wellmark.com, or call the Customer Service number on your ID card and request a copy of the Drug List.

Drugs will not be added to or removed from the Drug List until they have been evaluated by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is a group of practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety and effectiveness of new and existing medications and make any necessary changes to the Drug List.

The Drug List is subject to change.

Specialty Drugs

Specialty drugs are high-cost injectable, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling

(e.g., refrigeration) and administration. They are not available through the mail order drug program.

Specialty drugs may be covered under your Blue Rx Complete prescription drug benefits or under your medical benefits. To determine whether a particular specialty drug is covered under your Blue Rx Complete prescription drug benefits or under your medical benefits, consult the Wellmark Blue Rx Complete Drug List at Wellmark.com, check with your pharmacist or physician, or call the Customer Service number on your ID card.

Where to Purchase Prescription Drugs

Participating Pharmacies. You must purchase prescription drugs from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Drugs*, later in this section).

If you purchase drugs from nonparticipating pharmacies, you are responsible for the entire cost of the drug. To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies, visit our website at Wellmark.com, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Specialty Drugs. You must purchase specialty drugs through the specialty pharmacy program. The specialty pharmacy program is limited to CVS Specialty®. If you purchase specialty drugs outside the specialty pharmacy program, you are responsible for the entire cost of the drug. See *Specialty Pharmacy Program*, page 42.

Limits on Prescription Drug Coverage

We may exclude, discontinue, or limit coverage for any drug by removing it from the Drug List or by moving a drug to a

different tier on the Drug List for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- Over-the-counter drugs with similar properties become available or a drug's active ingredient is available in a similar strength in an over-the-counter product or as a nutritional or dietary supplement product available over the counter.
- There is a sound medical reason.
- Scientific evidence does not show that a drug works as well and is as safe as other drugs used to treat the same or similar conditions.
- A drug receives FDA approval for a new use.

Drugs, Services, and Items that are Not Covered

Drugs, services, and items that are not covered under your prescription drug benefits include, but are not limited to:

- Drugs not listed on the Wellmark Blue Rx Complete Drug List.
- Drugs purchased from nonparticipating pharmacies.
- Specialty drugs purchased outside the specialty pharmacy program.
- Drugs in excess of a quantity limitation. See *Quantity Limitations* later in this section.
- Antigen therapy.
- Drugs that are not FDA-approved.
- Experimental or investigational drugs.
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain.
- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug.
- Drugs determined to be abused or otherwise misused by you.
- Drugs that are lost, damaged, stolen, or used inappropriately.

- Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.
- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.
- Cosmetic drugs.
- Infused drugs. These may be covered under your medical benefits. See *Specialty Drugs*, page 26.
- Irrigation solutions and supplies.
- Medication Therapy Management (MTM) when billed separately.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Nicotine dependency drugs.
- Weight reduction drugs.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

See Also:

Prescription Drugs, page 25.

Prescription Purchases Outside the United States

To qualify for benefits for prescription drugs purchased outside the United States, all of the following requirements must be met:

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same name and dosage form as the FDA-approved drug's active ingredient.
- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.

- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician.

In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs with quantity limits, check with your pharmacist or physician, consult the Wellmark Blue Rx Complete Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the United States, the refill amount will not exceed a 90-day supply.

To receive authorization for an early refill, ask your pharmacist to call us.

Refills

To qualify for refill benefits, all of the following requirements must be met:

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your practitioner.
- The refill is not limited by state law.

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time.

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. Wellmark's medically necessary analysis and determinations apply to any service, supply, device, or drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. 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:
 - Nationally recognized utilization management standards as utilized by Wellmark; or
 - Credible scientific evidence published in peer-reviewed medical literature generally recognized by

the relevant medical community; and

- Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

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

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

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

receiving the services, to assume the payment responsibility.

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

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Member Eligibility

Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 61.

General Exclusions

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

Investigational or Experimental

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

chemical dependency treatment services, as applicable.

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

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

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

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

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a PPO or Participating provider in the Wellmark service area and:
 - The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and

- The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

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

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.

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 or Administrative Services

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

Provider Is Family Member

You are not covered for a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner) unless the provider is the only provider within a reasonable geographic distance and the provider is acting within the scope of his or her practice.

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 for which we learn or are notified by you, your provider, or our third party contractor that such services or supplies are related to a work related illness or injury, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. We will comply with our statutory obligation regarding payment on claims on which workers' compensation liability is unresolved. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if:

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

Benefit Limitations

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

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 13.
- If you receive benefits that reach a lifetime benefits maximum applicable to any specific service, then you are no longer eligible for benefits for that service under this group health plan. See *Benefits Maximums*, page 7, and *At a Glance—Covered and Not Covered*, page 9.
- If you do not obtain precertification for certain medical services, benefits can be reduced or denied. You are responsible for benefit reductions if you receive the services from an Out-of-Network Provider. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in South Dakota or Iowa will handle notification requirements for you. If you see a PPO Provider outside South Dakota or Iowa, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 45.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in South Dakota or Iowa will handle notification requirements for you. If you see a PPO Provider outside South Dakota or Iowa, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 45.

- If you do not obtain prior authorization for certain prescription drugs, benefits can be denied. See *Notification Requirements and Care Coordination*, page 45.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 37, and *Factors Affecting What You Pay*, page 53. 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 Provider.

5. Choosing a Provider

Medical

Provider Network

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

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

Non-PPO providers are either Participating or Out-of-Network. If you are unable to utilize a PPO Provider, it is usually to your advantage to visit what we call a *Participating Provider*. Participating Providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO.

Other providers are considered Out-of-Network, and you will usually pay the most for services you receive from them.

See *What You Pay*, page 3 and *Factors Affecting What You Pay*, page 53.

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.

Providers are independent contractors and are not agents or employees of Wellmark. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 19 and *Physicians and Practitioners*, page 24.

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

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

Pharmacies that contract with our pharmacy benefits manager are considered 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, the pharmacist should call the Pharmacist Helpline number on the back of your ID card. See *Choosing a Pharmacy* and *Specialty Pharmacy Program* later in this section.

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

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

Services Outside the Wellmark Service Area

BlueCard Program

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

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of South Dakota. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a PPO Provider. Always carry your ID card (or BlueCard) and present it to your provider when you receive care. Information on it, especially the ID number, is required to process your claims correctly.

PPO Providers may not be available in some states. In this case, when you receive covered services from a non-PPO provider (i.e., a Participating or Out-of-Network provider), you will receive many of the same advantages as when you receive covered services from a PPO Provider. However,

because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

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

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

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

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

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

BlueCard® Program

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

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

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

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

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

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

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

Out-of-Network Providers Outside the Wellmark Service Area

Your Liability Calculation. When covered 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 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 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 services as set forth in this coverage manual.

Care in a Foreign Country

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

Blue Cross Blue Shield Global® Core Program

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

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

Inpatient Services. In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. **You must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 69.

Submitting a Blue Cross Blue Shield Global Core Claim

When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider’s itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the Blue Cross Blue Shield Global Core

Service Center, or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week.

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

South Dakota and Iowa comprise the Wellmark service area.

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

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

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

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

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

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

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

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 54.

Prescription Drugs

Choosing a Pharmacy

Your prescription drug benefits are called Blue Rx Complete. Pharmacies that participate with the network used by Blue Rx Complete are called participating pharmacies. Pharmacies that do not participate with the network are called nonparticipating pharmacies.

You must purchase prescription drugs from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Pharmacy Program* later in this section). If you purchase drugs from nonparticipating pharmacies, you are responsible for the entire cost of the drug.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies, visit our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Always Present Your ID Card

If you do not have your ID card with you when you fill a prescription at a participating pharmacy, the pharmacist may not be able to access your benefit information. In this case:

- You must pay the full amount charged at the time you receive your prescription, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- You must file your claim to be reimbursed. See *Claims*, page 69.

Specialty Pharmacy Program

Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. You must purchase specialty drugs through the specialty pharmacy program. The specialty pharmacy program is limited to CVS Specialty®. You must register as a specialty pharmacy program user in order to fill your prescriptions through the specialty pharmacy program. For information on how to register, call the Customer Service number on your ID card or visit our website at *Wellmark.com*.

You are not covered for specialty drugs purchased outside the specialty pharmacy program.

The specialty pharmacy program administers the distribution of specialty drugs to the home and to physicians' offices.

Mail Order Drug Program

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

You must register as a mail service user in order to fill your prescriptions through the mail order drug program. For information on how to register, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Mail order pharmacy providers outside our mail order program are considered nonparticipating pharmacies. You are not covered for drugs purchased from nonparticipating mail order pharmacies.

See *Participating vs. Nonparticipating Pharmacies*, page 58.

6. Notification Requirements and Care Coordination

Medical

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

Providers and Notification Requirements

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

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

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

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 79. Also see *Authorized Representative*, page 81.

Precertification

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

Person Responsible for Obtaining Precertification	<p>You or someone acting on your behalf is responsible for obtaining precertification if:</p> <ul style="list-style-type: none"> ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to precertification from a PPO or Participating provider outside South Dakota or Iowa. <p>Your Provider should obtain precertification for you if:</p> <ul style="list-style-type: none"> ■ You receive services subject to precertification from a PPO Provider in South Dakota or Iowa; or ■ You receive inpatient services subject to precertification from a PPO or Participating provider outside South Dakota or Iowa. <p>Please note: If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.</p>
Process	<p>When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services.</p> <p>Wellmark will respond to a precertification request within:</p> <ul style="list-style-type: none"> ■ 24 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. <p>Precertification requests must include supporting clinical information to determine medical necessity of the service or admission.</p> <p>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.</p>

Importance	<p>If you choose to receive services subject to precertification, you will be responsible for the charges as follows:</p> <ul style="list-style-type: none"> ■ If you receive services subject to precertification from an Out-of-Network Provider and we determine that the procedure was not medically necessary you will be responsible for the full charge. ■ If you receive non-inpatient services from a PPO or Participating provider in another state or service area and we determine the procedure is medically necessary and otherwise covered, without precertification, benefits can be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. ■ If you are admitted to a PPO or Participating inpatient facility, the provider, not you, will be responsible for any reduction for failure to complete the precertification process. Please note: It is important that you are aware of precertification requirements to help ensure that they are met. ■ If you receive the services from an Out-of-Network Provider and we determine the procedure is medically necessary and otherwise covered, without precertification, benefits can be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed \$1,000 per admission. This reduction maximum does not apply to home health services. See <i>Maximum Allowable Fee</i>, page 55. You are subject to this benefit reduction only if you receive the services from an Out-of-Network Provider.
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Notification

Purpose	Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.
Applies to	For a complete list of the services subject to notification, visit <i>Wellmark.com</i> or call the Customer Service number on your ID card.
Person Responsible	<p>PPO Providers in the states of South Dakota and Iowa perform notification for you. However, you or someone acting on your behalf is responsible for notification if:</p> <ul style="list-style-type: none"> ■ You receive services subject to notification from a provider outside South Dakota or Iowa; ■ You receive services subject to notification from a Participating or Out-of-Network provider.
Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services or as soon as reasonably possible thereafter.

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 <i>Wellmark.com</i> or call the Customer Service number on your ID card.
Person Responsible for Obtaining Prior Approval	<p>You or someone acting on your behalf is responsible for obtaining prior approval if:</p> <ul style="list-style-type: none"> ■ 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 PPO or Participating provider outside South Dakota or Iowa. <p>Your Provider should obtain prior approval for you if:</p> <ul style="list-style-type: none"> ■ You receive services subject to prior approval from a PPO Provider in South Dakota or Iowa; or ■ You receive inpatient services subject to prior approval from a PPO or Participating provider outside South Dakota or Iowa. <p>Please note: If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.</p>
Process	<p>When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.</p> <p>Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within:</p> <ul style="list-style-type: none"> ■ 24 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. <p>Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.</p>

Importance	<p>If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial.</p> <p>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.</p> <p>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 <i>Appeals</i> 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.</p> <p>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.</p> <p>Note: When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See <i>Precertification</i> and <i>Notification</i> earlier in this section.</p>
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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 <i>Wellmark.com</i> or call the Customer Service number on your ID card.
Person Responsible	Wellmark
Process	<p>Wellmark may review your case to determine whether your current place or level of care is medically necessary.</p> <p>Responses to Wellmark's concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.</p>
Importance	Wellmark may require a change in the place or level of care in order to continue providing benefits. If we determine that your current facility setting or level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.

Case Management

Purpose	Case management is intended to identify and assist members with the most severe illnesses or injuries by collaborating with members, members' families, and providers to develop individualized care plans.
Applies to	<p>A wide group of members including those who have experienced potentially preventable emergency room visits; hospital admissions/readmissions; those with catastrophic or high cost health care needs; those with potential long term illnesses; and those newly diagnosed with health conditions requiring lifetime management. Examples where case management might be appropriate include but are not limited to:</p> <p>Brain or Spinal Cord Injuries</p> <p>Cystic Fibrosis</p> <p>Degenerative Muscle Disorders</p> <p>Hemophilia</p> <p>Pregnancy (high risk)</p> <p>Transplants</p>
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.

Prescription Drugs

Prior Authorization of Drugs

Purpose	Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary.
Applies to	Consult the Drug List to determine if a particular drug requires prior authorization. You can locate this list by visiting <i>Wellmark.com</i> . You may also check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.
Person Responsible	You are responsible for prior authorization.
Process	<p>Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription.</p> <p>Wellmark will respond to a prior authorization request within:</p> <ul style="list-style-type: none"> ■ 24 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. <p>Calls received after 4:00 p.m. are considered the next business day.</p>
Importance	If you purchase a drug that requires prior authorization but do not obtain prior authorization, you are responsible for paying the entire amount charged.

7. Factors Affecting What You Pay

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

Medical

Benefit Year

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

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

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

The benefit year is important for calculating:

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

- Benefit maximum.

How Coinsurance is Calculated

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

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

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

PPO and Participating Providers Outside the Wellmark Service Area

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

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
 - Deductible.
 - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

Often, the negotiated price will be a simple discount that reflects an actual price the local Host Blue paid to your provider.

Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges.

Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

- Deductible.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

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

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO

and Participating providers. All other providers are Out-of-Network Providers.

PPO Providers

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

- The PPO payment obligation amounts may be waived or may be less than the Participating and Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 7.
- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with Participating Providers. Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, the pharmacist should call the Pharmacist Helpline number on the back of your ID card. When you receive services from Participating Providers:

- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

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 other than those participating in the specialty pharmacy program 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 responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider will generally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from Out-of-Network Providers. See *Services Outside the Wellmark Service Area*, page 38.
- Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.

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 is based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee.

Payment Arrangements

Payment Arrangement Savings

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

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

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a Participating or PPO provider. For the majority of services, the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or PPO provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you 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 33.

- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
 - Deductible.
 - Coinsurance.
 - 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. PPO and Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Specialty Drug Manufacturer Discount Card Program

Certain specialty medications may qualify for manufacturer discount card programs which could lower your out-of-pocket costs for those products. Under many of these programs, the plan may reduce your deductible or coinsurance for the allowable amount for the specialty medication by an amount which is equivalent to the maximum benefit of the applicable coupon or rebate. This reduction shall not be implemented for any plan design that does not allow the member access to coupons or rebates. You will not receive credit toward your maximum out-of-pocket for any deductible or coinsurance amounts that are applied to a manufacturer coupon or rebate.

This Specialty Drug Manufacturer Discount Card Program is offered as part of your plan's exclusive specialty pharmacy network with CVS/caremark's affiliate CVS Specialty. The list of specialty drugs eligible for this Specialty Drug Manufacturer Discount Card Program is subject to change as determined by CVS Specialty.

Drug Company Rebates

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

Prescription Drugs

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.

The benefit year is important for calculating:

- Deductible.
- Out-of-pocket maximum.

Wellmark Blue Rx Complete Drug List

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

The Drug List is maintained with the assistance of practicing physicians, pharmacists, and Wellmark’s pharmacy department.

To determine if a drug is covered, you or your physician must consult the Drug List. If a drug is not on the Drug List, it is not covered.

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Although only drugs listed on the Drug List are covered, physicians are not limited to prescribing only the drugs on the list. Physicians may prescribe any medication, but only medications on the Drug List are covered. **Please note:** A medication on the Drug List will not be covered if the drug is specifically excluded under your Blue Rx Complete prescription drug benefits, or other limitations apply.

If a drug is not on the Wellmark Blue Rx Complete Drug List and you believe it

should be covered, refer to *Exception Requests for Non-Formulary Prescription Drugs*, page 71.

The Wellmark Blue Rx Complete Drug List is subject to change.

Tiers

The Wellmark Blue Rx Complete Drug List also identifies which tier a drug is on:

Tier 1. Most generic drugs and some brand-name drugs that have no medically appropriate generic equivalent. Tier 1 drugs have the lowest payment obligation.

Tier 2. Drugs appear on this tier because they either have no medically appropriate generic equivalent or are considered less cost-effective than Tier 1 drugs. Tier 2 drugs have a higher payment obligation than Tier 1 drugs.

Tier 3. Drugs appear on this tier because they are less cost-effective than Tier 1 or Tier 2 drugs. Tier 3 drugs have a higher payment obligation than Tier 1 or Tier 2 drugs.

Tier 4. Drugs available as combination products or lifestyle drugs. Tier 4 drugs have the same payment obligation as Tier 3 drugs.

Generic and Brand Name Drugs

Generic Drug

Generic drug refers to an FDA-approved “A”-rated generic drug. This is a drug with active therapeutic ingredients chemically identical to its brand name drug counterpart.

Brand Name Drug

Brand name drug is a prescription drug patented by the original manufacturer. Usually, after the patent expires, other manufacturers may make FDA-approved generic copies.

Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a

generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, Wellmark's pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

What You Pay

In most cases, when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent, Wellmark will pay only what it would have paid for the medically appropriate equivalent generic drug. You will be responsible for your payment obligation for the medically appropriate equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician.

In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs with quantity limits, check with your pharmacist or physician or consult the Wellmark Blue Rx Complete Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

Amount Charged and Maximum Allowable Fee

Amount Charged

The retail price charged by a pharmacy for a covered prescription drug.

Maximum Allowable Fee

The amount, established by Wellmark using various methodologies and data (such as the

average wholesale price), payable for covered drugs.

The maximum allowable fee may be less than the amount charged for the drug.

Participating vs. Nonparticipating Pharmacies

You must purchase prescription drugs from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Drugs*, page 26). Purchases from nonparticipating pharmacies are not covered. If you purchase drugs from nonparticipating pharmacies, you are responsible for the cost of the drug.

Your payment obligation for the purchase of a covered prescription drug at a participating pharmacy is the lesser of your copayment or coinsurance, the maximum allowable fee, or the amount charged for the drug.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies, visit our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Preferred vs. Non-Preferred Specialty Drugs

The amount you pay for specialty drugs covered under your Blue Rx Complete prescription drug benefits depends on whether the specialty drug is categorized as preferred or non-preferred.

Preferred Specialty Drugs have been proven to be safe, effective, and favorably priced compared to non-preferred alternatives that treat the same condition. Drugs may also be classified as preferred because no alternative drug exists.

Non-Preferred Specialty Drugs are drugs without sufficiently documented clinical evidence that they provide a

significant benefit over available preferred alternatives.

To determine whether a specialty drug is preferred or non-preferred, consult the Wellmark Blue Rx Complete Drug List at *Wellmark.com*. Also see *Specialty Drugs*, page 26.

Special Programs

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

Visit our website at *Wellmark.com* or call us to determine whether your prescription qualifies.

Specialty Drug Manufacturer Discount Card Program

Certain specialty medications may qualify for manufacturer discount card programs which could lower your out-of-pocket costs for those products. Under many of these programs, the plan may reduce your deductible, coinsurance, or copayment for the allowable amount for the specialty medication by an amount which is equivalent to the maximum benefit of the applicable coupon or rebate. This reduction shall not be implemented for any plan design that does not allow the member access to coupons or rebates. You will not receive credit toward your maximum out-of-pocket for any deductible, coinsurance, or copayment amounts that are applied to a manufacturer coupon or rebate.

This Specialty Drug Manufacturer Discount Card Program is offered as part of your plan's exclusive specialty pharmacy network with CVS/caremark's affiliate CVS Specialty. The list of specialty drugs eligible for this Specialty Drug Manufacturer Discount Card

Program is subject to change as determined by CVS Specialty.

Savings and Rebates

Payment Arrangements

The benefits manager of this prescription drug program has established payment arrangements with participating pharmacies that may result in savings.

Drug Company Rebates

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

8. Coverage Eligibility and Effective Date

Eligible Members

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

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

- A 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, policyholder's or retiree's tax return; and
 - Enrolled in and receiving Medicare benefits due to disability; or
 - Enrolled in and receiving Social Security benefits due to disability.

Documentation will be required.

Providing Social Security Numbers or Tax Identification Numbers

In order for Wellmark to report your coverage status to the federal government, you must provide to Wellmark your Social Security number or tax identification number and the Social Security numbers or tax identification numbers of all members covered under your coverage and of any member(s) added to your coverage. If you have a newborn child while you are covered under your group health plan, you must notify us of the newborn's social security number within six months of the child's birth. The IRS requires that Wellmark report this information using the Social Security number or tax identification number of the plan member and each dependent. If Wellmark does not have Social Security or tax identification numbers, we will be unable to report and send the information needed to complete federal tax returns. If you have not previously provided your Social Security number or tax identification number to

Wellmark for all members covered under your coverage, you should contact us by calling the Customer Service number on your ID card. If you do not provide the Social Security numbers or taxpayer identification numbers to Wellmark for this purpose, you will be subject to a \$50 penalty per violation imposed by the Internal Revenue Service.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 65.

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 65.

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

Changes to Information Related to You or to Your Benefits

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

Qualified Medical Child Support Order

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

A QMCSO specifies information such as:

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

A Qualified Medical Child Support Order cannot require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of South Dakota law 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 to enroll for coverage if spouses are eligible for coverage under this plan. If your employer or group sponsor offers more than one group health plan, the event also allows you to move from one plan option to another.

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA coverage.
- You or your eligible spouse or your dependent loses eligibility for creditable coverage or 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).
- 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 62.
- 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 (if spouses are eligible for coverage under this plan). Legal separation, also, may result in removal from coverage. If you become legally separated, notify your employer or group sponsor.
- Medicare eligibility. If you become eligible for Medicare, you must notify your employer or group sponsor immediately. If you are eligible for this group health plan other than as a current employee or a current employee's spouse (if spouses are eligible for coverage under this plan), your Medicare eligibility may terminate this coverage.

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

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

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:

- Divorce, legal separation, or annulment.
- Your dependent child loses eligibility for coverage.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP).
- 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.

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

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.
- Your employer or group sponsor ends its membership in an association that is the basis of this coverage.
- The number of individuals covered under this group health plan falls below the number or percentage of eligible individuals required to be covered.
- We decide to discontinue offering this group health benefit plan in the group market in South Dakota by giving written notice to you and your employer or group sponsor and the Director of Insurance at least 90 days prior to termination.
- We decide to nonrenew all group health benefit plans delivered or issued for delivery to employers in South Dakota by giving written notice to you and your employer or group sponsor and the Director of Insurance at least 180 days prior to termination.

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

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

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

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

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

Fraud or Intentional Misrepresentation of Material Facts

Your coverage will terminate immediately if:

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

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

- We may declare this group health plan void retroactively from the effective date of coverage following a 30-day written notice. In this case, we will recover any claim payments made, minus any premiums paid.

- 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 premiums have been paid in full.

Coverage Continuation

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

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.

South Dakota Law. Chapter 58-18 of the South Dakota Codified Laws applies if you receive health care coverage through an employer with fewer than 20 employees. If this law applies, you may be eligible to continue this health benefits plan.

If coverage ends because employment is terminated (because of reduction of hours, self termination, and other approved reasons) continuation coverage is provided for up to 18 months. Coverage must be the same as the coverage for active employees. The employee is responsible for the

premium, which will not be more than 102 percent of the premium for active employees.

If a beneficiary becomes disabled during the first 60 days of continuation coverage, continuation may be extended for up to 29 months.

If the coverage is terminated for any of the following reasons, coverage may extend for up to 36 months:

- Former spouses and dependents lose coverage due to divorce or legal separation from the employee.
- Surviving spouses and dependents lose coverage due to death of the employee.
- A dependent is no longer eligible for coverage.
- Dependents lose coverage when the employee qualifies for Medicare.

The premium will not be more than 102 percent of the premium for active employees up to the 18th month. Beginning with month 19, the premium will not exceed 150 percent of the premium for active employees.

Your employer or group sponsor must provide you with written notice of your right to continue your coverage within 14 days of the last day you are considered employed or your coverage ends.

After receiving the notice, you have 30 days to notify your employer or group sponsor that you want to continue your coverage. Your request should be written. Assuming you received the proper notice, the right to continue your coverage ends 60 days after the date of termination of your employment or the date you were given notice of your right to continue this health care program, whichever comes later.

If you lose your health care coverage and think this law applies to you, contact your employer or group sponsor for help with forms and information about the cost of continuing your coverage.

Chapter 58-18C of the South Dakota Codified Laws applies if you receive health care coverage through an employer and your employer ceases operations, fails to pay premiums, or cancels coverage without notice to employees. In any of these events, continuation of coverage for yourself and your eligible dependents may extend for up to 12 months. During this time, you will be financially responsible for payment of premiums. The premium will not exceed 125 percent of the group rate.

Continuation will be available only to an employee who has been continuously insured under the group health plan, or under any creditable coverage which it replaced, during the six-month period ending with the termination.

Written notice of termination of group coverage shall be provided, within 10 days, by the employer to each covered employee. In the event the employer fails to submit premium payment to Wellmark resulting in loss of coverage or cancels the coverage and does not notify the employees, the employee has 60 days from the date he or she was first notified of loss of coverage to elect continuation coverage. In the event the employer ceases operations, the employee has 30 days from the date he or she was first notified of the loss of coverage to elect continuation coverage and pay the premium from the date of termination. The election period for continuation of coverage under this section will not exceed 90 days from the date the coverage was terminated.

Any former employee who is under continuation coverage at the time an employer ceases operations and terminates the policy, fails to pay premiums, or fails to notify employees or former employees of the cancellation of coverage, is eligible to remain on continuation coverage for the remainder of the continuation term or 12 months, whichever is less, if timely election is made and payments received.

10. Claims

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

When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. Participating and PPO providers file claims for you.
- Purchase prescription drugs from a participating pharmacy but do not present your ID card.
- Pay in full for a drug that you believe should have been covered.

Your submission of a prescription to a participating pharmacy is not a filed claim and therefore is not subject to appeal procedures as described in the *Appeals* section. However, you may file a claim with us for a prescription drug purchase you think should have been a covered benefit.

Wellmark must receive claims within 180 days following the date of service of the claim or if you have other coverage that has primary responsibility for payment then within 180 days of the date of the other carrier's explanation of benefits.

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 Covered Under Your Medical Benefits Claim Form.

For prescription drugs covered under your medical benefits (not covered under your Blue Rx Complete prescription drug

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.

Blue Rx Complete Prescription Drug Claim Form. For prescription drugs covered under your Blue Rx Complete prescription drug benefits, complete the following steps:

- Use a separate claim form for each covered family member and each pharmacy.
- Complete all sections of the claim form. Include your daytime telephone number.
- Submit up to three prescriptions for the same family member and the same pharmacy on a single claim form. Use additional claim forms for claims that exceed three prescriptions or if the prescriptions are for more than one family member or pharmacy.
- Attach receipts to the back of the claim form in the space provided.

3. Sign the Claim Form

4. Submit the Claim

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

Medical Claims and Claims for Drugs Covered Under Your Medical Benefits. Send the claim to:

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

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

Blue Rx Complete Prescription Drug Claims. 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 73.

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.

Exception Requests for Non-Formulary Prescription Drugs

Prescription drugs that are not listed on the Wellmark Blue Rx Complete Drug List are not covered. However, you may submit an exception request for coverage of a non-formulary drug (i.e., a drug that is not included on the Wellmark Blue Rx Complete Drug List). The form is available at *Wellmark.com* or by calling the Customer Service number on your ID card. Your prescribing physician or other provider must provide a clinical justification supporting the need for the non-formulary drug to treat your condition. The provider should include a statement that:

- All covered formulary drugs on any tier have been ineffective; or
- All covered formulary drugs on any tier will be ineffective; or
- All covered formulary drugs on any tier would not be as effective as the non-formulary drug; or
- All covered formulary drugs would have adverse effects.

Wellmark will respond within 72 hours of receiving the Exception Request for Non-Formulary Prescription Drugs form. For expedited requests, Wellmark will respond within 24 hours.

In the event Wellmark denies your exception request, you and your provider will be sent additional information regarding your ability to request an independent review of our decision. If the independent reviewer approves your exception request, we will treat the drug as a covered benefit for the duration of your prescription. You will be responsible for out-of-pocket costs (for example: deductible, copay, or coinsurance, if applicable) as if the non-formulary drug is on the highest tier of the Wellmark Blue Rx Complete Drug List. Amounts you pay will

be counted toward any applicable out-of-pocket maximums. If the independent reviewer upholds Wellmark's denial of your exception request, the drug will not be covered, and this decision will not be considered an adverse benefit determination, and will not be eligible for further appeals. You may choose to purchase the drug at your own expense.

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that are not on the Wellmark Blue Rx Complete Drug List. It is not available for items that are specifically excluded under your benefits, such as cosmetic drugs, convenience packaging, non-FDA approved drugs, infused drugs, most over-the-counter medications, nutritional, vitamin and dietary supplements, or antigen therapy. The preceding list of excluded items is illustrative only and is not a complete list of items that are not eligible for the process.

11. Coordination of Benefits

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

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

Other Coverage

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

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

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 state law.
- School accident-type coverage.
- Benefits for nonmedical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

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

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

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services or obtain a covered prescription drug, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 180 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

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

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

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

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the

secondary plan and the other plan is the primary plan.

- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Notwithstanding the preceding rules, when you present your Blue Rx Complete ID card to a pharmacy as the primary payer, your Blue Rx Complete prescription drug benefits are primary for prescription drugs purchased at the pharmacy. If, under the preceding rules, your Blue Rx Complete prescription drug benefits are secondary and you present your Blue Rx Complete ID card to a pharmacy as the secondary payer, your Blue Rx Complete prescription drug benefits are secondary for prescription drugs purchased at the pharmacy.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits

within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Dependent Children

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

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

pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

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

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited to the amount we would have paid had this plan been primary.
- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 84.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the

claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Effects on the Benefits of this Plan

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

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

Right of Recovery

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

Plans That Provide Benefits as Services

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the service from the primary plan, to the extent benefits for the services are covered by the primary plan

and have not already been paid or provided by the primary plan.

Coordination with Medicare

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

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

Medicare Part B Drugs

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

Working Aged

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

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

Working Disabled

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

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

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these

requirements, Medicare is the secondary payer during the first 30 months of Medicare eligibility if both of the following are true:

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

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

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

12. Appeals

Right of Appeal

You have the right to one full and fair review in the case of an adverse benefit determination 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.
- A prior authorization request for prescription drugs.

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 81.

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.

For a prescription drug appeal, you also must submit:

- Name and phone number of the pharmacy.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

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

Where to Send Internal Appeal

Wellmark Blue Cross and Blue Shield of
South Dakota
Special Inquiries
Station 351
1601 W. Madison St.
Sioux Falls, SD 57104

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.

Assistance and Legal Action

You may contact the South Dakota Division of Insurance at any time for assistance with the appeal process at:

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, SD 57501
tel.: 605-773-3563

You may not start legal action against us prior to the expiration of 60 days after receiving written notice of an adverse determination.

13. General Provisions

Contract

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

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

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

Interpreting this Coverage Manual

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

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 as shown by payment of the premium.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 65.

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

We are committed to protecting the privacy of your health information. We will request, use, or disclose your health information only as permitted or required by law. Wellmark has issued a *Privacy Practices Notice*. This notice is available upon request or at *Wellmark.com*.

We will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

Treatment

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

Payment

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

Health Care Operations

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

Other Disclosures

We will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person. 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 Blue365®, identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Value-Based Programs

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

health care information, including claims information, for purposes of helping support their delivery of health care services to you.

Nonassignment

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

Governing Law

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

Legal Action

You may not start any legal action against us prior to the expiration of 60 days after receiving written notice of an adverse determination, described in the *Appeals* section.

You may 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 three 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 under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

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

Acquisition by States of Rights of Third Parties

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

Medicaid Reimbursement

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

Subrogation

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

- The responsible person or that person's insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;

- Other insurance coverage including, but not limited to, homeowner's, motor vehicle, or medical payments insurance; and
- Any other payment from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

Right of Subrogation

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

Right of Reimbursement

If you 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 Wellmark 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 Wellmark on the claim.

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

You agree to recognize Wellmark's rights to subrogation and reimbursement. These rights provide Wellmark with a priority over any money paid by a third party to you relative to the amount paid by Wellmark, including priority over any claim for nonmedical charges, or other costs and expenses. Wellmark will assume all rights of recovery, to the extent of payment, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have

received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement

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

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement

agreement between you and the third party or his insurer or your insurer;

- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by Wellmark.

Send this information to:

Wellmark Blue Cross and Blue Shield of
South Dakota
1601 West Madison, P.O. Box 5023
Sioux Falls, SD 57117-5023

You also agree to all of the following:

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

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

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

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

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

Workers' Compensation

If you have received benefits under this 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.

Premium

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

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

We have the right to change the monthly premium following 45 days written notice to your employer or group sponsor.

Notice

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

Wellmark Blue Cross and Blue Shield of
South Dakota
1601 West Madison, P.O. Box 5023
Sioux Falls, SD 57117-5023

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

Submitting a Complaint

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

Consent to Telephone Calls and Text or Email Notifications

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

Glossary

The definitions in this section are terms that are used in various sections of this 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 or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

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

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

Compounded Drugs. Compounded prescription drugs are produced by combining, mixing, or altering ingredients by a pharmacist to create an alternate strength or dosage form tailored to the specialized medical needs of an individual patient when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs.

Creditable Coverage. Any of the following categories of coverage:

- Group health plan (including government and church plans).
- Health insurance coverage (including group and individual 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 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.
- A short-term limited-duration policy.
- A college plan.

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

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

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

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.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

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

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

Member. A person covered under this group health plan.

Nonparticipating Pharmacy. A pharmacy that does not participate with the network used by your prescription drug benefits.

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

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

Participating Pharmacy. A pharmacy that participates with the network used by your prescription drug benefits. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-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 a preferred provider program. Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers.

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

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

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

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

Specialty Drugs. Drugs that are typically used for treating or managing chronic illnesses. These drugs are subject to restricted distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or patient education that may not be provided by a retail pharmacy. Some specialty drugs may be taken orally, but others may require administration by injection or inhalation.

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

Urgent Care Centers are classified by us as such in South Dakota or 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 South Dakota or Iowa facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.

We, Our, Us. Wellmark Blue Cross and Blue Shield of South Dakota.

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

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

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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, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ກັບ. (TTY: 888-781-4262.)

주의: 한국어를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တစ်ခုခုပြော-နားထောင်ကုန်သိမ်းကုန်သိမ်းတော့တော့မတော့မတော့, လာတော့လာတော့လဲ, ဆိုလားနီလီလဲ. ဆဲးကျိုးသူ ၈၀၀-၅၂၄-၉၂၄၂ ဖုန်းနံပါတ် (TTY: ၈၈၈-၇၈၁-၄၂၆၂) တက်ပါ.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከማርኛ የሚናገሩ ከሆኑ፣ የቋንቋ አገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውለው ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yánílti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojí' hóline' 800-524-9242 doodaii' (TTY: 888-781-4262)

