Wellmark

Wellmark Blue HMO℠
health plan

Outline of coverage for individual and family ACA plans

Table of Contents

Choosing a provider	2
About Wellmark Blue HMO℠ Network	4
Benefits	6
Limitations	9
Exclusions	10
Plan overview	12
Blue Rx Essentials℠ drug coverage	16
Notification requirements	20
Evaluating the latest technology	21
Notices of privacy practices	21
Wellmark's internal protection of Personal Health Information	21
General provisions	22
Health and wellness programs	23
Terms to know	24

You should read your benefits policy carefully. This Outline of Coverage for Wellmark Blue HMO plans provides a brief description of the important features of your benefits policy. This is not your benefits policy. The benefits policy itself includes your benefit provisions and sets forth in detail the rights and obligations of both you and Wellmark.

THEREFORE, IT IS IMPORTANT THAT YOU READ YOUR BENEFITS POLICY CAREFULLY.

If you have questions about Wellmark Blue HMO plans and the application submission process, please contact Wellmark's customer service at **800-819-0893.** If you are a current Wellmark member, please call the customer service number located on the back of your ID card.

Premium payments may be made on a calendar month or semi-annual calendar year basis. For example:

Payment frequency	Description
Monthly	**Premium payment would be for the first day of the month through the last day of such month through electronic funds transfer (EFT) only.**
Semi-annual	**Premium payment would be for the calendar period of either:** Jan. 1 through June 30 or July 1 through Dec. 31

In any year in which there is a mid-year adjustment in the amount of premium(s), the member will have the following obligation:

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

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

Your authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless you notify your bank no less than three business days before a scheduled withdrawal to stop the payment. You will be responsible for any fee assessed by your bank for stop-payment orders that you make. To safeguard the financial information of our members, Wellmark cannot accept telephone call requests from policyholders/certificate holders to change bank account information on an existing ACH/EFT account. You can update your bank account information via myWellmark®. If you do not have online access to electronically update your bank information, you must complete and submit the Automatic Withdrawal Authorization Form.

Choosing a provider

Providers who participate with this network are called Wellmark Blue HMO network providers. You can feel secure knowing that through the Wellmark Blue HMO network, you have access to more than 24,000 providers across the state and access to emergency care nationwide.[1] **Generally, there are no benefits for services received outside of the Wellmark Blue HMO network, except for emergencies or accidental injuries.**

This plan requires that you select a designated primary care provider. Your Wellmark Blue HMO plan features lower out-of-pocket costs when you establish and visit a designated primary care provider (PCP). The relationship between you and your PCP should be one that's long-term. Think of your PCP as your medical "home" – they should be someone you feel comfortable with, who can listen to you and understand your needs and then direct your care appropriately. Building a long-term relationship with your PCP can be associated with better overall health and lower hospital and emergency room use. You must choose a primary care provider who participates in the Wellmark Blue HMO network, who is available to accept you or your family members and who is one of the following types of providers: family practitioners, general practitioners, geriatricians, internal medicine practitioners, advanced registered nurse practitioners (ARNP), physician assistants and pediatricians.

Select your designated PCP in your myWellmark account at myWellmark.com or in the myWellmark app.

Providers who do not participate with this plan may be called out-of-network, nonparticipating providers. With Wellmark Blue HMO plans, it is to your advantage to visit your designated primary care provider (personal provider) for most covered services. If your designated PCP is unable to diagnose or treat your condition, they may refer you to another Wellmark Blue HMO network provider. Generally, benefits are available only when received from Wellmark Blue HMO network providers. To determine if a provider participates with this medical benefits plan, ask your provider, refer to the Find a Provider or Hospital tool on Wellmark.com or call the customer service number on your ID card. Our provider directory is also available upon request by calling the customer service number on your ID card.

Please note: Even though a facility may be a Wellmark Blue HMO network facility, particular providers within the facility may not be Wellmark Blue HMO network providers. Examples include out-of-network, nonparticipating physicians on the staff of a Wellmark Blue HMO network hospital, home medical equipment suppliers and other independent providers. Therefore, when you are referred by a Wellmark Blue HMO network provider to another provider or when you are admitted into a facility, always ask if the providers are Wellmark Blue HMO network providers. Always carry your ID card and present it when you receive services. Information on it, especially the ID number, is required to process your claims correctly. Pharmacies do not participate with the Wellmark Blue HMO network.

Referrals

If you require services from a provider other than your primary care provider, typically a specialist, you will be referred to a provider in the Wellmark Blue HMO network. If you require services that are not available from a specialist within the Wellmark Blue HMO network, you will be referred to a provider outside the Wellmark Blue HMO network who has expertise in diagnosing and treating your condition. Wellmark must approve out-of-network referrals before you receive services or the services will not be covered.

Note: Even when your referral outside the Wellmark Blue HMO network is approved, you may be responsible for the difference between the amount an out-of-network provider bills and our payment amount. Even when your out-of-network referral is approved, you are still responsible for complying with notification requirements.

Designated primary care providers (PCPs)

Designated primary care providers are a type of provider you go to for your primary care. PCPs include general/family practitioners, geriatricians, internal medicine practitioners, pediatricians, physician assistants and/or physician associates and advanced registered nurse practitioners.

In the case of preventive care visits and benefits, services must be received from an in-network provider for preventive benefits to be covered and cost-share waived.

Balance billing

This is the difference between the billed charge of an out-of-network provider who does not participate in the traditional BlueCard® program and what Wellmark will pay for a specific service, procedure or supply. When you receive emergency care and, in some cases, non-emergency services from a provider who is not part of the Wellmark Blue HMO network, you may not be responsible for paying this difference. If you consent to receiving a non-emergency service from a provider that is not part of the Wellmark Blue HMO network, you may be balance-billed. To avoid being balance-billed for non-emergency services, select a health care provider who participates in the Wellmark Blue HMO network. Non-emergency care is not covered for out-of-network providers. Balance-billed amounts do not apply toward your deductible or out-of-pocket maximum and are not used to calculate your coinsurance percentage.

Benefits for most covered services are available only when received from Wellmark Blue HMO network providers. However, when you receive services in an in-network facility and are provided covered services by an out-of-network ancillary provider, in-network cost-share will be applied and accumulate toward the out-of-pocket maximum. For this purpose, ancillary providers include emergency room physicians, anesthesiologists, pathologists, radiologists, neonatologists or hospitalists. Even though we do not have contracts with out-of-network providers and they may not accept our payment arrangements, you may not be responsible for any difference

[1] Wellmark Blue Cross and Blue Shield network numbers as of May 2024.

between the billed charge and our settlement amount for the services from the out-of-network ancillary provider depending on the type of provider.

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

Blue Distinction® Centers[1]

Blue Distinction Centers (BDC) are facilities that are recognized for their proven expertise in delivering specialty care. The Blue Distinction program recognizes providers and hospitals for their expertise and exceptional quality in delivering care, from general health and wellness to more complex and specialty procedures.

The following services must be received at a Blue Distinction Center in order to be covered:

- Bariatric surgery.
- Organ transplants excluding pancreas and small bowel transplants.

These centers have demonstrated their commitment to quality care, resulting in better outcomes for these types of surgeries.

[1] Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for providers located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each provider's cost of care is evaluated using data from its Local Blue Plan. Providers in CA, ID, NY, PA and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. National criteria for BDC and BDC+ are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in-network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

About Wellmark Blue HMO℠ Network

The Wellmark Blue HMO Plans outlined here and detailed in the policies are Health Maintenance Organization (HMO) health plans designed to provide coverage for hospital, medical and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out-of-hospital care. Covered services are subject to deductible and copayment provisions or other limitations set forth in the benefits policy.

This coverage is available to you (individual coverage) or to you and your family (family coverage), including your spouse and/or eligible dependent children; or to your dependents only (child-only coverage). A child-only benefits policy is a single benefits policy in which the primary applicant is age 20 or younger or a benefits policy of multiple siblings in which the primary applicant is the youngest child and is age 20 or younger. You will pay the premium required for coverage directly to Wellmark.

Office services received from a Wellmark Blue HMO network provider

Covered office services include office visits and consultations, X-rays, ultrasounds, laboratory testing, minor surgery, and most outpatient X-rays and laboratory testing billed by a Wellmark Blue HMO network facility when your Wellmark Blue HMO network provider refers you to the facility.

Services outside the Wellmark Blue HMO network

Generally, there are no benefits for medical services received outside of the Wellmark Blue HMO network, except in the following situations:

- Accidental injuries.
- Emergencies.
- Pre-approved out-of-network referrals.

BlueCard® Program

Wellmark Health Plan of Iowa, Inc., is an affiliate of Wellmark, Inc., doing business as Wellmark Blue Cross® and Blue Shield® of Iowa and is an independent licensee of the Blue Cross and Blue Shield Association. We have relationships with other Blue Cross and/or Blue Shield Plans. These relationships are generally referred to as Inter-Plan Programs. Whenever you obtain services outside the Wellmark Blue HMO network, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program. These programs ensure that members of any Blue Plan have access to the advantages of Participating Providers throughout the U.S. Participating Providers have a contractual arrangement with the Blue Cross or Blue Shield Plan in their home state ("Host Blue"). The Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

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

In an emergency situation, seek care at the nearest hospital emergency room. Whenever possible, before receiving services outside the Wellmark Blue HMO network, you should always ask the provider if they participate with a Blue Cross and/or Blue Shield Plan in that state. To locate BlueCard providers in any state, call **800-810-BLUE** or visit bcbs.com.

When you receive covered services from BlueCard providers outside the Wellmark Blue HMO network, all of the following statements are true:

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

Out-of-network/nonparticipating providers

When you receive covered services for accidental injuries, emergencies, pre-approved out-of-network referrals or guest membership from out-of-network, nonparticipating providers, all of the following statements are true:

- Out-of-network, nonparticipating providers are not responsible for filing your claims. If you need a claim form or have questions on how to submit a claim, please call the customer service phone number located on your ID card.
- We do not have contracts with out-of-network, nonparticipating providers and they may not agree to accept our payment arrangements. Therefore, you may be responsible for any difference between the amount charged and our payment.
- We make claims payments to you, not out-of-network, nonparticipating providers.
- You are responsible for notification requirements.

Eligibility for Wellmark Blue HMO network coverage

All persons seeking coverage with the Wellmark Blue HMO network must be residents of Iowa and live in the Wellmark Blue HMO network service area. If coverage is issued, please note, there are generally no benefits for medical services outside the Wellmark Blue HMO network except for emergency or accidental injuries.

Guest membership

Covered dependents attending college out of state are eligible to become a guest member any time they are outside the Wellmark Blue HMO network area for at least 90 days. The time limit of guest membership for covered dependents attending college out of state is one year but can be extended by calling customer service.

To set up a guest membership, follow the guidelines listed below:

- Before a covered dependent leaves the Wellmark Blue HMO network area to attend college, they should call the customer service number on their ID card.

This plan does not include coverage for pediatric dental services

This health plan does not include pediatric dental services as described under the Federal Patient Protection and Affordable Care Act. Pediatric dental coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier or health insurance agent if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

Blue Distinction Centers

Generally, there are no benefits for the following services received outside of a Blue Distinction Center:

- Bariatric surgery.
- Organ transplants excluding pancreas and small bowel transplants.

Blue Distinction Centers demonstrate quality care, treatment expertise and better overall patient results. The Blue Distinction® program recognizes providers and hospitals for their expertise and exceptional quality in delivering care, from general health and wellness to more complex and specialty procedures.

Benefits

Approved hospital/health care facility services

Wellmark Blue HMO plans provide medically necessary services and supplies related to the treatment of an illness or injury as an inpatient in a facility.

Approved health care facilities include ambulatory surgical facilities, hospitals and nursing facilities. All Wellmark Blue HMO plans also consider community mental health centers and facilities for treatment of chemical dependency to be approved health care facilities.

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

Inpatient services

All Wellmark Blue HMO plans cover:

- Accidental injury care.
- Anesthetics and their administration.
- Blood and blood administration.
- Chemotherapy services.
- Maternity.
- Dialysis services.
- Drugs and biologicals.
- Education services for diabetes.
- Emergency care.
- General nursing care.
- Inhalation therapy.
- Intravenous administration.
- Medical and surgical supplies such as dressing and casts.
- Mental health and chemical dependency treatment.
- Nutritional counseling.
- Occupational therapy — see *Limitations* section.
- Physical therapy — see *Limitations* section.
- Speech therapy treatment — see *Limitations* section.

Outpatient services

All Wellmark Blue HMO plans cover:

- Accidental injury care.
- Anesthetics and their administration.
- Chemotherapy services.
- Dialysis services.
- Drugs and biologicals.
- Education services for diabetes.
- Emergency care.
- Inhalation therapy.
- Intravenous administration.
- Medical and surgical supplies such as dressing and casts.
- Mental health and chemical dependency treatment.
- Occupational therapy.
- Physical therapy.
- Rehabilitative speech therapy treatment.
- Musculoskeletal services.

Approved provider services

The following list describes approved provider services for all Wellmark Blue HMO plans:

- Accidental injury services.
- Applied Behavioral Analysis (ABA) Therapy.
- Allergy testing and treatment.
- Anesthetics and their administration.
- Certain dental services
- Chemotherapy.
- Maternity.
- Nutritional counseling.
- Concurrent care.
- Dialysis services.
- Emergency care.
- Genetic testing and related counseling in certain circumstances.
- Hearing examinations.
- Medical services-other than surgical or obstetrical.
- Mental health and chemical dependency services.
- Musculoskeletal services.
- Occupational therapy.
- Physical therapy.
- Preventive care, including:
  - Implanted and injected contraceptives and contraceptive medical devices — oral contraceptives are covered under your drug benefits policy.
  - Immunizations.
  - Routine gynecological exams.
  - Mammograms.
  - One routine physical examination and related services per member per benefit period.
  - Routine pap smears.
  - Well-child care including age appropriate pediatric preventive services until the child reaches the age of seven.
  - Radiation therapy.
- Rehabilitative speech therapy treatment.
- Surgical services.
- Reconstructive surgery.
- Fertility and infertility services.
  - Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
  - Fertility and infertility services until you receive artificial insemination, in vitro fertilization or any related fertility or infertility treatment or transfer procedure.
- X-ray and laboratory services
- Pediatric vision — vision services for members under age 19 (one routine vision examination per benefit year).
- Telehealth services.

Note: Even though a facility may participate in the Wellmark Blue HMO network, other providers within the facility may not participate with the Wellmark Blue HMO network. If you are receiving non-emergency services, it is important to ask if the provider participates in the Wellmark Blue HMO network before you receive covered services.

Organ transplant coverage

Coverage is available under all Wellmark Blue HMO plans for transplants of the heart, lung, pancreas, kidney, small bowel, liver and for certain bone marrow/stem cell transfer transplants only when provided at a Blue Distinction Center.

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

Note: Transplants are subject to case management and services are required to be provided at a Blue Distinction Center (BDC). This requirement does not apply to pancreas and small bowel transplants.

Other covered services for all plans

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

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

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

- Ambulance services (professional air or ground).
- Home infusion therapy.
- Home medical equipment.
- Short-term home skilled nursing if given by a registered nurse (RN) or licensed practical nurse (LPN) from an agency accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or a Medicare-certified agency and if coordinated by a case manager.
- Oxygen and equipment administration.
- Prescription drugs and medicines administered in the vein or muscle covered under the Blue Rx Essentials℠ managed prescription drug program.
- Prosthetic devices and braces.

Home health services

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

Covered services and supplies include:

- Home health aide services.
- Short-term home skilled nursing visits if given by a registered nurse (RN) or licensed practical nurse (LPN) from an agency accredited by the JCAHO or a Medicare-certified agency and if coordinated by a case manager. Short-term home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, provide teaching to caregivers for ongoing care or provide short-term treatments that can be safely administered in a home setting.
- Inhalation therapy.
- Medical equipment and supplies.
- Medical social services.
- Prescription drugs and medicines administered in the vein or muscle.
- Occupational therapy.
- Oxygen and equipment for its administration.
- Parenteral and enteral nutrition.
- Physical therapy.
- Prosthetic devices and braces.
- Speech therapy treatment.

Hospice services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include the same services as described under "Home Health Services" as well as hospice respite care from a facility approved by Medicare or 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.

Pediatric vision

Wellmark's pediatric vision benefits are administered through Avēsis[1].

Benefits are available for children under age 19. Your deductible is waived for all plans except Wellmark Bronze HDHP HMO HSA Qualified. Wellmark Bronze HDHP HMO HSA Qualified plans will waive the deductible for routine vision exams only. The details:

- One routine vision exam per benefit year at no cost.
- One frame and one pair of lenses per benefit year or contact lenses instead of frames and lenses.
  - 50 percent coinsurance for one frame per benefit year.
  - 50 percent coinsurance per benefit year for non-medically necessary contact lenses.
  - Medically necessary contact lenses.

Virtual visit[2]

Virtual visit, also referred to as telehealth services, includes covered medical services delivered by an in-network provider via interactive audio-visual technology, web-based mobile device or similar electronic-based communication network or as otherwise required by Iowa law. Virtual visit is the quickest and easiest way to see a provider or mental health professionals who can treat the most common medical conditions and prescribe medication, if needed, right from your computer, tablet or phone from the comfort of home.

When a member uses Doctor On Demand® for a virtual visit, they will pay a $0 copay (when enrolled in a Wellmark Traditional plan) and services include:

- Preventive behavioral health coaching.
- Virtual primary care (applies to Wellmark Bronze Traditional plans only).

[1] Wellmark's pediatric vision coverage is administered by Avēsis, an independent company providing network and claims administration on behalf of Wellmark for pediatric vision benefits.

[2] Wellmark's virtual health care visit benefit is made available through an independent company, Doctor On Demand, Inc. and the telemedicine services are provided by licensed physicians practicing within a group of independently owned professional practices. Doctor On Demand, Inc. does not itself provide any physician, mental health or other health care provider services. Doctor On Demand® operates subject to state laws. Doctor On Demand offers medical care in 50 states. Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician. Doctor On Demand does not provide Wellmark Blue Cross and Blue Shield products or services. Doctor On Demand is a separate company providing an online telehealth solution for Wellmark members. Doctor On Demand® is a registered mark of Included Health, Inc.

Limitations

Your Wellmark Blue HMO coverage is limited as follows:

Cosmetic surgery

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

Breast reconstruction after a mastectomy

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

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of breast surgery for cancer treatment or prevention in high risk members, including lymphedemas.

Musculoskeletal treatment

You are covered for outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease. Musculoskeletal treatment performed for maintenance is not a covered benefit.

Treatment of mental health conditions and chemical dependency (MH/CD)

All plans provide coverage for mental health and chemical dependency treatment subject to these limitations:

- For mental health:
  - 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.
  - 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.
- For substance abuse:
  - 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.
  - 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.

Occupational, physical and speech therapy

Wellmark Blue HMO plans provide coverage for occupational, speech and physical therapy subject to the benefit terms outlined in your benefits policy:

- Occupational therapy does not cover:
  - Occupational therapy supplies.
  - Occupational therapy performed for maintenance.
  - Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Speech therapy does not cover:
  - 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.
- Physical therapy does not cover:
  - Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
  - Physical therapy performed for maintenance.

Hospice respite care

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 for hospice respite care are limited to:

- 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.

Exclusions

The following services are excluded or are not considered medically necessary by Wellmark Health Plan of Iowa and will not be covered in the Wellmark Blue HMO policies:

Counseling and educational services

All Wellmark Blue HMO plans exclude coverage for:

- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for weight reduction, nutritional instruction for the control of gastrointestinal conditions, reading programs for dyslexia, for any medical, mental health or substance abuse condition.
- Weight reduction programs or supplies (including dietary supplements, nutritional products, or exercise counseling, classes or equipment), whether or not weight reduction is medically appropriate.
- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.

Mental health treatment

All Wellmark Blue HMO plans exclude coverage for:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders.
- Sensitivity, shyness and social withdrawal disorders.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.
- Services and supplies associated with sexual disorders, sex therapy or sex education.

Fertility and infertility

All Wellmark Blue HMO plans exclude coverage for:

- Elective abortion.
- Infertility services if the infertility is the result of voluntary sterilization.
- The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures or for any other reason or service; freezing and storage of sperm, oocytes or embryos; surrogate parent services.
- Artificial insemination, in vitro fertilization or any transfer procedure. If you have any of these procedures done, benefits for all types of fertility or infertility services (including drug-induced stimulation of ovulation) will end beginning on the day you receive the noncovered service.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Miscellaneous

All Wellmark Blue HMO plans exclude coverage for:

- Anesthesia, local or topical billed separately from a related surgical or medical procedure.
- Orthotics.
- Complications of a non-covered service, supply, device or drug (complications arising from an elective abortion are covered).
- Dental services except as specified and limited in the benefits policy.
- Elastic stockings and bandages.
- Extended home skilled nursing, which is treatment provided in the home by a registered nurse (RN) or licensed practical nurse (LPN) who is associated with JCAHO or a Medicare-certified agency. Additionally, this treatment 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 RN or LPN.
- Hearing aids.
- Investigational treatment.
- Maxillary and mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.
- Motor vehicle special equipment.
- Non-medical services.
- Personal convenience items.
- Rehabilitative speech therapy treatment not provided by a licensed or certified speech pathologist. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.
- Routine vision care for members over age 19.
- Services furnished to you prior to the date your benefits policy begins.
- Dental extractions, dental restorations or orthodontic treatments for temporomandibular joint syndrome.
- Travel or lodging costs.
- Wigs or hairpieces.

Organ transplants

All Wellmark Blue HMO plans exclude coverage for:

- Expenses related to purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services or supplies that have been determined to not be medically necessary.
- Expenses of transporting living donor.
- Expenses of transporting the recipient when the transplant organ for the recipient is not available for transplant.
- Services outside a Blue Distinction Center (BDC). This requirement does not apply to pancreas and small bowel transplants.

Provider types

These providers are excluded on all Wellmark Blue HMO plans:

- Provider, if an immediate family member.

Covered by other programs or laws

All Wellmark Blue HMO plans exclude coverage for:

- Illness or injury sustained while on active military status.
- 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.
- Services provided under a direct primary care agreement.
- Services or supplies when someone else has the legal obligation to pay for services, has an agreement to not submit claims for services or, without this health plan, there would not be a charge.

Therapy, self-motivation and other programs

All Wellmark Blue HMO plans exclude coverage for:

- Acupuncture.
- 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.
- Custodial or sanitaria care or rest cures.
- Educational or recreational therapy.
- Massage therapy.
- Occupational therapy supplies and therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Rehabilitative speech therapy treatment not provided by a licensed or certified speech pathologist. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.
- Self-help or self-cure programs, products or drugs.
- Services and supplies as an inpatient provided primarily for diagnostic evaluation, physical therapy or occupational therapy.

Additional exclusions

- Routine foot care.
- Periodic physicals or health examinations, screening or immunization procedures that are performed solely for school, sport, employment, insurance, licensing or travel.
- Services provided outside a Blue Distinction Center (BDC) for bariatric surgery and organ transplants, excluding pancreas and small bowel transplants.

Generally, there are no medical benefits for services received outside of the Wellmark Blue HMO network, except for emergencies or accidental injuries.

Plan overview

Plan Name	Wellmark Bronze Traditional HMO℠	Wellmark Standard Bronze HMO℠
Metallic Tier	Bronze	Bronze
Available on Exchange?	Yes	Yes
Preventive care	FREE[1]	FREE[1]
Annual benefit: Deductible	**Single:** $7,200 **Family[2]:** $14,400	**Single:** $7,500 **Family[2]:** $15,000
Annual benefit: Out-of-pocket maximum	**Single:** $11,500 **Family[2]:** $23,000	**Single:** $12,000 **Family[2]:** $24,000
Lifetime benefit maximum	Unlimited	Unlimited
Coinsurance: in-network	50%	50%
Office services: Out-of-network	Not covered except for emergency and accidental injury only	Not covered except for emergency and accidental injury only
PCP[3] office visit, walk-in clinic, independent lab services, facility lab/X-ray, virtual visit (includes labs and X-rays done in a visit for Standard plans only; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	Designated PCP $75 copay Other PCP $90 copay $90 copay urgent care/walk-in clinic 50% coinsurance after deductible for other services done in an office setting	PCP $50 copay Non-PCP $100 copay $75 copay urgent care/walk-in clinic 50% coinsurance after deductible for independent labs
Virtual visit through Doctor On Demand	$0 copay (also includes virtual primary care)[4]	$50 copay Doctor on Demand & PCP $100 copay Non-PCP[4]
Physical therapy, occupational therapy or speech pathology	50% coinsurance after deductible or $90 copay (dependent on place of service and type of service) Cost-share is waived for Mental Health related services when done in an office setting	$50 copay (office/outpatient)
Specialist office visit (includes labs and X-rays done in a visit for Standard plans only; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	$150 copay	$100 copay
Emergency room (includes physician, facility, labs and X-rays)	50% coinsurance after deductible	50% coinsurance after deductible
All other services (i.e. X-rays outside of office visit for Standard plans only, X-rays during an office visit for Traditional plans, ultrasounds, inpatient, ambulance, skilled nursing facility, outpatient physician and facility services, diagnostic imaging/studies and radiation therapy, nuclear medicine, diagnostic mammograms, diagnostic testing, durable medical equipment)	50% coinsurance after deductible	50% coinsurance after deductible
Rx formulary	Blue Rx Essentials℠	Blue Rx Essentials℠
Prescription drug benefits	Generic (Tier 1): $35 copay Generic/Preferred brand (Tier 2), Generic/Non-Preferred brand (Tier 3), Biosimilars, Preferred specialty/Non-preferred specialty[5]: 50% Coinsurance after deductible (Health/Drug Deductible & OPM aggregates; deductible waived for Tier 1)	Generics (Tier 1): $25 copay Generic/Preferred brand (Tier 2): $50 copay after deductible Generic/Non-Preferred brand (Tier 3): $100 copay after deductible Specialty[5]: $500 copay after deductible (Health/Drug Deductible & OPM aggregates; deductible waived for Tier 1)
Office-administered specialty medical drug cost share	50% coinsurance after deductible	$500 copay after deductible[6]
Pediatric dental[7]	Not included in health plan	Not included in health plan
Pediatric vision[8]	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses

[1] Preventive care must be received from an in-network provider in the Wellmark Blue HMO network.

[2] The family deductible and out-of-pocket maximum can be met through any combination of family members. No one member will be required to meet more than the single deductible or out-of-pocket maximum amount to receive benefits for covered services during a benefit period.

[3] The primary care office copay applies to certified nurse midwives, family practitioners, general practitioners, obstetricians/gynecologists, geriatricians, pediatricians, physician assistants and/or physician associates, advanced registered nurse practitioners, and Wellmark Blue HMO PCP provider types who are not your designated PCP for Traditional plans. This lower office copay applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.

[4] The lower virtual visit copay applies to in-network virtual visits only. Out-of-network not covered.

[5] Drugs listed on the PrudentRx Drug list will have 30% coinsurance. If you enroll with PrudentRx to get copayment assistance for your eligible specialty medications, you will have $0 out-of-pocket responsibility for prescriptions listed on the PrudentRx drug list.

[6] The office visit copayment applies in addition to this office administered specialty medical drug copayment.

[7] This policy does not include pediatric dental services as described in the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, producer or Iowa's Marketplace Exchange if you wish to purchase dental coverage or a stand-alone dental services product.

[8] Pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19, an independent company providing network and claims administration on behalf of Wellmark for the pediatric vision benefits.

Plan overview, continued

Plan Name	Wellmark Bronze HDHP HMO HSA Qualified
Metallic Tier	$ Bronze
Available on Exchange?	Yes
Preventive care	FREE[1]
Annual benefit: Deductible	**Single:** $8,500 **Family[2]:** $17,000
Annual benefit: Out-of-pocket maximum	**Single:** $8,500 **Family[2]:** $17,000
Lifetime benefit maximum	Unlimited
Coinsurance: in-network	0%
Office services: Out-of-network	Not covered except for emergency and accidental injury only
PCP[3] office visit, walk-in clinic, independent lab services, facility lab/X-ray, virtual visit (includes labs and X-rays done in a visit; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	Deductible
Virtual visit through Doctor On Demand	Deductible
Physical therapy, occupational therapy or speech pathology	Deductible
Specialist office visit (copay does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	Deductible
Emergency room (includes physician, facility, labs and X-rays; copays waived if admitted as inpatient)	Deductible
All other services (i.e. X-rays outside of office visit, X-rays during an office visit for Traditional plans, ultrasounds, inpatient, ambulance, skilled nursing facility, outpatient physician and facility services, diagnostic imaging/studies and radiation therapy, nuclear medicine, diagnostic mammograms, diagnostic testing, durable medical equipment)	Deductible
Rx formulary	Blue Rx Essentials℠
Prescription drug benefits	Medical deductible applies After deductible, plan pays 100% of covered drug (Health/Drug Deductible & OPM aggregates)
Office-administered specialty medical drug cost share	Medical Deductible applies After deductible, plan pays 100% of covered drugs
Pediatric dental[4]	Not included in health plan
Pediatric vision[5]	Deductible applies (deductible waived for eye exam)

[1] Preventive care must be received from an in-network provider in the Wellmark Blue HMO network.

[2] The family deductible and out-of-pocket maximum can be met through any combination of family members. No one member will be required to meet more than the single deductible or out-of-pocket maximum amount to receive benefits for covered services during a benefit period.

[3] The primary care office copay applies to certified nurse midwives, family practitioners, general practitioners, obstetricians/gynecologists, geriatricians, pediatricians, physician assistants and/or physician associates, advanced registered nurse practitioners. This lower office copay applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.

[4] This policy does not include pediatric dental services as described in the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, producer or Iowa's Marketplace Exchange if you wish to purchase dental coverage or a stand-alone dental services product.

[5] Pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19, an independent company providing network and claims administration on behalf of Wellmark for the pediatric vision benefits.

Plan Name	Wellmark Silver Traditional HMO℠	Wellmark Standard Silver HMO℠
Metallic Tier	$ Silver	$ Silver
Available on Exchange?	Yes	Yes
Preventive care	FREE[1]	FREE[1]
Annual benefit: Deductible	**Single:** $5,000 **Family[2]:** $10,000	**Single:** $6,400 **Family[2]:** $12,800
Annual benefit: Out-of-pocket maximum	**Single:** $8,500 **Family[2]:** $17,000	**Single:** $10,300 **Family[2]:** $20,600
Lifetime benefit maximum	Unlimited	Unlimited
Coinsurance: In-network	30%	40%
Office services: Out-of-network	Not covered except for emergency and accidental injury only	Not covered except for emergency and accidental injury only
PCP[3] office visit, walk-in clinic, independent lab services, facility lab/X-ray, virtual visit (includes labs and X-rays done in a visit for Standard plans only; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	Designated PCP $45 copay Other PCP $60 copay $60 copay urgent care/walk-in clinic 30% coinsurance after deductible for other services done in an office setting	PCP $40 copay Non-PCP $80 copay $60 copay urgent care/walk-in clinic 40% coinsurance after deductible for independent labs
Virtual visit through Doctor On Demand	$0 copay[4]	$40 copay Doctor on Demand & PCP $80 copay Non-PCP[4]
Physical therapy, occupational therapy or speech pathology	30% coinsurance after deductible or $60 copay (dependent on place of service and type of service) Cost-share is waived for Mental Health related services when done in an office setting	$40 copay (office/outpatient)
Specialist office visit (includes labs and X-rays done in a visit for Standard plans only; copay does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	$75 copay	$80 copay
Emergency room (includes physician, facility, labs and X-rays)	30% coinsurance after deductible	40% coinsurance after deductible
All other services (i.e. X-rays outside of office visit for Standard plans only, X-rays during an office visit for Traditional plans, ultrasounds, inpatient, ambulance, skilled nursing facility, outpatient physician and facility services, diagnostic imaging/studies and radiation therapy, nuclear medicine, diagnostic mammograms, diagnostic testing, durable medical equipment)	30% coinsurance after deductible	40% coinsurance after deductible
Rx formulary	Blue Rx Essentials℠	Blue Rx Essentials℠
Prescription drug benefits	Generic (Tier 1): $30 copay Generic/Preferred brand (Tier 2): $60 copay Generic/Non-Preferred brand (Tier 3): $140 copay Biosimilars: $220 copay Preferred specialty[5]: $300 copay Non-preferred specialty[5]: $500 copay (Health/Drug Deductible & OPM aggregates)	Generics (Tier 1): $20 copay Generic/Preferred brand (Tier 2): $40 copay Generic/Non-Preferred brand (Tier 3): $80 copay after deductible Specialty[5]: $350 copay after deductible (Health/Drug Deductible & OPM aggregates; deductible waived for Tier 1 & 2)
Office-administered specialty medical drug cost share	$300 copay[6]	$350 copay after deductible[6]
Pediatric dental[7]	Not included in health plan	Not included in health plan
Pediatric vision[8]	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses

[1] Preventive care must be received from an in-network provider in the Wellmark Blue HMO network.

[2] The family deductible and out-of-pocket maximum can be met through any combination of family members. No one member will be required to meet more than the single deductible or out-of-pocket maximum amount to receive benefits for covered services during a benefit period.

[3] The primary care office copay applies to certified nurse midwives, family practitioners, general practitioners, obstetricians/gynecologists, geriatricians, pediatricians, physician assistants and/or physician associates, advanced registered nurse practitioners, and Wellmark Blue HMO PCP provider types who are not your designated PCP for Traditional plans. This lower office copay applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.

[4] The lower virtual visit copay applies to in-network virtual visits only. Out-of-network not covered.

[5] Drugs listed on the PrudentRx Drug list will have 30% coinsurance. If you enroll with PrudentRx to get copayment assistance for your eligible specialty medications, you will have $0 out-of-pocket responsibility for prescriptions listed on the PrudentRx drug list.

[6] The office visit copayment applies in addition to this office administered specialty medical drug copayment.

[7] This policy does not include pediatric dental services as described in the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, producer or Iowa's Marketplace Exchange if you wish to purchase dental coverage or a stand-alone dental services product.

[8] Pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19, an independent company providing network and claims administration on behalf of Wellmark for the pediatric vision benefits.

Plan Name	Wellmark Gold Traditional HMO℠	Wellmark Standard Gold HMO℠
Metallic Tier	Gold	Gold
Available on Exchange?	Yes	Yes
Preventive care	FREE[1]	FREE[1]
Annual benefit: Deductible	**Single:** $1,750 **Family[2]:** $3,500	**Single:** $2,500 **Family[2]:** $5,000
Annual benefit: Out-of-pocket maximum	**Single:** $8,000 **Family[2]:** $16,000	**Single:** $8,600 **Family[2]:** $17,200
Lifetime benefit maximum	Unlimited	Unlimited
Coinsurance: In-network	25%	25%
Office services: Out-of-network	Not covered except for emergency and accidental injury only	Not covered except for emergency and accidental injury only
PCP[3] office visit, walk-in clinic, independent lab services, facility lab/X-ray, virtual visit; (includes labs and X-rays done as part of office visit for Standard plans only; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	Designated PCP $15 copay Other PCP $30 copay $30 copay urgent care/walk-in clinic 25% coinsurance after deductible for other services done in an office setting	PCP $30 copay Non-PCP $60 copay $45 copay urgent care/walk-in clinic 25% coinsurance after deductible for independent labs
Virtual visit through Doctor On Demand	$0 copay[4]	$30 copay Doctor on Demand & PCP $60 copay Non-PCP[4]
Physical therapy, occupational therapy or speech pathology	25% coinsurance after deductible or $30 copay (dependent on place of service and type of service) Cost-share is waived for Mental Health related services when done in an office setting	$30 copay (office/outpatient)
Specialist office visit (includes labs and X-rays done as part of office visit for Standard plans only; does not include diagnostic imaging/studies and radiation therapy including but not limited to CT, MEG, MRA, MRI, PET, nuclear medicine, ultrasounds, diagnostic mammograms and diagnostic testing)	$45 copay	$60 copay
Emergency room (includes physician, facility, labs and X-rays)	25% coinsurance after deductible	25% coinsurance after deductible
All other services (i.e. X-rays outside of office visit for Standard plans only, X-rays during an office visit for Traditional plans, ultrasounds, inpatient, ambulance, skilled nursing facility, outpatient physician and facility services, diagnostic imaging/studies and radiation therapy, nuclear medicine, diagnostic mammograms, diagnostic testing, durable medical equipment)	25% coinsurance after deductible	25% coinsurance after deductible
Rx formulary	Blue Rx Essentials℠	Blue Rx Essentials℠
Prescription drug benefits	Generic (Tier 1): $20 copay Generic/Preferred brand (Tier 2): $60 copay Generic/Non-Preferred brand (Tier 3): $125 copay Biosimilars: $215 copay Preferred specialty[5]: $300 copay Non-preferred specialty[5]: $400 copay (Health/Drug Deductible & OPM aggregates)	Generics (Tier 1): $15 copay Generic/Preferred brand (Tier 2): $30 copay Generic/Non-Preferred brand (Tier 3): $60 copay Specialty[5]: $250 copay (Health/Drug Deductible & OPM aggregates)
Office-administered specialty medical drug cost share	$300 copay[6]	$250 copay after deductible[6]
Pediatric dental[7]	Not included in health plan	Not included in health plan
Pediatric vision[8]	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses	50% coinsurance for one frame per benefit year 50% coinsurance for non-medically necessary contact lenses in lieu of eyeglasses

[1] Preventive care must be received from an in-network provider in the Wellmark Blue HMO network.

[2] The family deductible and out-of-pocket maximum can be met through any combination of family members. No one member will be required to meet more than the single deductible or out-of-pocket maximum amount to receive benefits for covered services during a benefit period.

[3] The primary care office copay applies to certified nurse midwives, family practitioners, general practitioners, obstetricians/gynecologists, geriatricians, pediatricians, physician assistants and/or physician associates, advanced registered nurse practitioners, and Wellmark Blue HMO PCP provider types who are not your designated PCP for Traditional plans. This lower office copay applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.

[4] The lower virtual visit copay applies to in-network virtual visits only. Out-of-network not covered.

[5] Drugs listed on the PrudentRx Drug list will have 30% coinsurance. If you enroll with PrudentRx to get copayment assistance for your eligible specialty medications, you will have $0 out-of-pocket responsibility for prescriptions listed on the PrudentRx drug list.

[6] The office visit copayment applies in addition to this office administered specialty medical drug copayment.

[7] This policy does not include pediatric dental services as described in the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a standalone product. Please contact your insurance carrier, producer or Iowa's Marketplace Exchange if you wish to purchase dental coverage or a stand-alone dental services product.

[8] Pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19, an independent company providing network and claims administration on behalf of Wellmark for the pediatric vision benefits.

Blue Rx Essentials℠ drug coverage

Most prescription drugs are covered under Blue Rx Essentials, your managed drug program. Wellmark Blue HMO members must fill their prescriptions through any of the more than 63,000 participating pharmacies nationwide[1] — whether in or out of state — and will have their claims filed electronically by the pharmacy. Specialty drugs must be purchased through the specialty pharmacy network. Blue Rx Essentials retail pharmacies, as well as specialty pharmacies, have point-of-sale computer access to current information to screen for duplicate therapies or interactions with drugs dispensed by other Blue Rx Essentials Network pharmacies.

Blue Rx Essentials Prescription Drug Card Plan

When filling a prescription, it is important to show your Wellmark Blue HMO ID card to confirm that the pharmacy participates in the Blue Rx Essentials network. The pharmacist uses the Rx BIN number to file your claims electronically and to determine how much you pay when picking up your prescription. The Rx BIN number is on your Wellmark Blue HMO ID card.

The Blue Rx Essentials Drug List

Often there is more than one medication available to treat the same medical condition. The Blue Rx Essentials Drug List contains drugs and pharmacy durable medical equipment devices physicians recognize as medically effective for a wide range of health conditions.

The Blue Rx Essentials Drug List is a reference list that includes generic and brand-name prescription drugs and pharmacy durable medical equipment devices that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Essentials prescription drug benefits. The Blue Rx Essentials 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 or pharmacy durable medical equipment device is covered, you must consult the Blue Rx Essentials Drug List. You are covered for drugs and pharmacy durable medical equipment devices listed on the Blue Rx Essentials Drug List. **If a drug or pharmacy durable medical equipment device is not listed on the Drug List, it is not covered.** If you need help determining if a particular drug or pharmacy durable medical equipment device is on the Blue Rx Essentials 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.

New drugs or pharmacy durable medical equipment devices will not be added to the Drug List until they have been evaluated by Wellmark's Pharmacy and Therapeutics (P&T) Committee. We will periodically update the list to reflect these evaluations and to reflect the changing drug market in general. Although only drugs and pharmacy durable medical equipment devices listed on the Drug List are covered, Wellmark Blue HMO network providers are not limited to prescribing only the drugs or pharmacy durable medical equipment devices on the list. Wellmark Blue HMO network providers may prescribe any medication, but only medications on the Drug List are covered unless it is a non-formulary drug and an exception has been approved for coverage. A medication on the Drug List will not be covered if the drug or device is specifically excluded under your prescription drug plan or other limitations apply. If a drug or device is not on the Blue Rx Essentials Drug List and you believe it should be covered, refer to the exception request for exception request. The Blue Rx Essentials Drug List is subject to change.

Understanding tiers and what you pay

Drugs are categorized into tiers. The Blue Rx Essentials Drug List identifies which tier a drug is on. The tier is also important in determining the amount you pay for your prescriptions.

Blue Rx Essentials

- **Tier 1** — Most generic drugs and some brand-name drugs that have no generic equivalent.
- **Tier 2** — Drugs appear on this tier because they either have no generic equivalent or are considered less cost-effective than Tier 1 drugs.
- **Tier 3** — Drugs appear on this tier because they are less cost-effective than Tier 1 or Tier 2 drugs.
- **Biosimilars** — This tier is made up of certain biosimilar medications. These are copies of original biologic medications that are equally safe and effective.
- **Preferred Specialty** — Drugs have 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 without sufficiently documented clinical evidence that they provide a significant benefit over available preferred alternatives.
- **Pharmacy DME** — Devices available on this tier include select durable medical equipment (DME) that are used in conjunction with a drug and may be obtained from a pharmacy.

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

Guidelines for drug coverage

To be covered, a prescription drug or pharmacy durable medical equipment device must meet all of the following criteria:

- Listed on the Drug List.

[1] CVS Health, 2023

- Can be legally obtained in the U.S. 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 their license.
- Dispensed by a recognized licensed participating retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy network, through the mail order drug program or dispensed and billed by a hospital or other facility as a take-home drug for a short-term supply.
- Medically necessary for your condition.
- Reviewed, evaluated and approved for addition to the Drug List by Wellmark's P&T Committee.

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 that are not covered

Drugs not covered include but are not limited to:

- Drugs indicated on the Blue Rx Essentials Drug List as non-formulary drug and an exception has not been approved by Wellmark for coverage.
- Drugs purchased from nonparticipating pharmacies.
- Specialty drugs purchased outside the specialty pharmacy network unless provided by your physician.
- Drugs in excess of a quantity limitation.
- Drugs that are not FDA-approved.
- Drugs that are not approved to be covered by Wellmark's P&T Committee, under any circumstances. These drugs are not eligible for an exception request for coverage pursuant to the exception request for non-formulary prescription drugs. These drugs are excluded from your pharmacy benefit as indicated on the Wellmark Blue Rx Essentials Drug List.
- Prescription drugs (including GLP-1s) when prescribed for weight reduction are not covered. Please note: Certain GLP-1s that are prescribed for diabetes or other FDA-approved indicators may be covered when prior authorization and medical criteria are met.
- 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 medical devices, such as intrauterine devices and diaphragms. These are covered under your medical benefits.
- 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.
- Irrigation solutions and supplies.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- The 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.

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 your Wellmark Blue HMO Plan network provider.
- 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 Wellmark Blue HMO network provider.
- 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.

If traveling within the U.S., the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the U.S., the refill amount will not exceed a 90-day supply. To receive authorization for an early refill, ask your pharmacist to call us.

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 Wellmark Blue HMO network provider. 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 Wellmark Blue HMO network provider, consult the Blue Rx Essentials Drug List at Wellmark.com or call the customer service number on your ID card.

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. In some cases prior authorization may also allow a drug that is normally excluded to be covered if it is part of a specific treatment plan and medically necessary.
- **Applies to** — Prior authorization is required for a number of particular drugs. Visit Wellmark.com or check with your pharmacist or Wellmark Blue HMO network provider to determine whether prior authorization applies to a drug that has been prescribed for you.
- **Person responsible** — Your prescribing practitioner is responsible for obtaining prior authorization.
- **Process** — Ask your Wellmark Blue HMO network provider to call us with the necessary information. If your Wellmark Blue HMO network provider 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. We will respond to a prior authorization request within:
  - 72 hours in a medically urgent situation.
  - 5 days in a non-medically urgent situation. Calls received after 4 p.m. are considered the next business day.
- **Importance** — If you purchase a drug that requires prior authorization but do not request prior authorization, you are responsible for paying the entire amount charged.

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 Essentials 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.

Prescription maximum
30 day retail
90 day retail maintenance
30 day mail order
90 day mail order maintenance
30 day specialty

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.

Biosimilars

A biosimilar is a biologic drug. It is highly similar to a biologic drug already approved by the FDA — the original biologic. Biosimilars also have no meaningful differences from the original biologic. This means you can expect the same safety and effectiveness from the biosimilar over the course of treatment as you would the original biologic.

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 Blue Rx Essentials prescription drug benefits. To determine whether a particular specialty drug is covered under your Blue Rx Essentials prescription drug benefits, consult the Blue Rx Essentials Drug List at Wellmark.com or call the customer service number on your ID card.

Specialty pharmacy network

Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. You must purchase specialty drugs through the specialty pharmacy network. For information, call the customer service number on your ID card or visit our website at Wellmark.com/member/specialty-drugs. You are not covered for specialty drugs purchased outside the specialty pharmacy network unless the specialty drug is covered under your medical benefits. The specialty pharmacy network administers the distribution of specialty drugs to the home and to physicians' offices.

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. You may not receive credit toward your maximum out-of-pocket for any out-of-pocket 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, PrudentRx. The list of specialty drugs eligible for this Specialty Drug Manufacturer Discount Card Program is subject to change as determined by PrudentRx.

PrudentRx will assist you by helping you enroll in drug manufacturer copay assistance programs. If you are taking a medication included on the PrudentRx drug list, PrudentRx will contact you directly to enroll. If you enroll with PrudentRx to get copayment assistance for your eligible specialty medication, and you are not on a high deductible health plan, you will have $0 out of-pocket responsibility for prescriptions covered under the PrudentRx drug list. If you are on a high deductible health plan, you will have $0 out-of-pocket responsibility on your PrudentRx eligible drugs once your deductible is met. If you choose to opt out of the program, either by affirmatively opting out or not returning PrudentRx's phone call, you may be responsible for the full cost share related to specialty

medications. The PrudentRx drug list can be found at Wellmark.com.

Preventive items and services

Preventive items and services received at a participating licensed retail pharmacy, including certain items or services recommended with an "A" or "B" rating by the U.S. Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are covered. To determine if a particular preventive item or service is covered, consult the Blue Rx Essentials Drug List or call the customer service number on your ID card.

Drug company rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services. Drug manufacturers may offer rebates to pharmacy benefits managers. Any rebate received by Wellmark will be used to offset the cost of benefit administration. The rebates will not be allocated to your specific claims and they will not be considered when determining your payment obligations.

Exception request for non-formulary prescription drugs

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that have been reviewed and evaluated by the Wellmark P&T Committee and are indicated on the Wellmark Blue Rx Essentials Drug List as Non-Formulary (NF). Generally, non-formulary drugs 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 Blue Rx Essentials 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 offer a clinical justification supporting the need for the non-formulary drug to treat your condition.

This exception process is not available for items that are specifically excluded under your benefits as indicated on the Wellmark Blue Rx Essentials Drug List, such as cosmetic drugs, convenience packaging, non-FDA-approved drugs, drugs not approved to be covered by Wellmark's P&T Committee, 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. These drugs are excluded from your pharmacy benefit as indicated on the Wellmark Blue Rx Essentials Drug List.

Prescription purchases outside the U.S.

To qualify for benefits for prescription drugs purchased outside the U.S., 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 have 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 Wellmark Blue HMO network provider if prescribed in the U.S.

Notification requirements

The following are notification requirements you or your Wellmark Blue HMO network provider should follow to receive the maximum benefits available under your benefits policy.

Precertification

The purpose of precertification is to help determine whether a service or admission to a facility is medically necessary. If you choose to have these services performed even though we were unable to certify the medical necessity of the services, you will be responsible for the charges.

For a complete list of the services subject to precertification, visit Wellmark.com or call the customer service number listed on your ID card.

Wellmark Blue HMO network providers obtain precertification for you. However, you or someone acting on your behalf are responsible for precertification if:

- You are admitted to a facility outside Iowa.
- You receive services subject to precertification from a nonparticipating provider.

If you have questions about whether or not a precertification request has been received by Wellmark, call customer service at the phone number on your ID card.

Concurrent review

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.

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

Wellmark may review your case to determine whether your current level of care is medically necessary. Responses to Wellmark's concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.

Laboratory services, home/durable medical equipment or prosthetic devices outside the Wellmark Blue HMO network

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/rented equipment or shipped equipment. If the provider does not have a contractual relationship with the Blue Plan, that provider will be considered a nonparticipating provider and you will be responsible for the entire amount charged.

Continuous glucose monitors and external insulin pumps that do not require implantation by your provider may be obtained through your prescription drug benefits.

Prior approval

Before you receive treatment for certain services, supplies or procedures, prior approval is required. Prior approval helps determine whether a proposed treatment plan is medically necessary and is a covered benefit under the benefits policy. Without prior approval for certain services, we cannot confirm that a proposed treatment plan is a benefit of your benefits policy. If prior approval is requested and approved by Wellmark, the service will be approved for a specific time period. (Even if you receive prior approval for a service, inpatient admissions may be subject to inpatient admission notification.)

Wellmark Blue HMO providers request prior approval for you. However, you or someone acting on your behalf are responsible for prior approval if:

- You are admitted to a facility outside Iowa
- You receive services subject to prior approval from a nonparticipating provider

For a complete list of services for which prior approval is required or to ask about any other service, call the phone number listed on your ID card or visit Wellmark.com.

Change of residence

You must notify us prior to relocating outside the Wellmark geographic service area because you will have no benefits for medical services provided outside of the Wellmark Blue HMO network except for emergencies or accidental injuries.

Notification

The purpose of notification is to help determine whether an admission to a facility is medically necessary. If you choose to have these services performed even though we were unable to certify the medical necessity of the services, you will be responsible for the charges.

Wellmark Blue HMO network providers perform notification for you. However, you or someone acting on your behalf are responsible for notification if:

- You are admitted to a facility outside Iowa.
- You receive services subject to notification from a nonparticipating provider.

For a complete list of services subject to notification, visit Wellmark.com or call the customer service number listed on your ID card.

Evaluating the latest technology

At Wellmark, we regularly review the latest procedures, drugs, devices and methods that will improve medical outcomes.

For more information, please call the customer service number located on the back of your ID card.

Notices of privacy practices

You can visit the following link: Wellmark.com/Inform to read more about:

- How your medical information may be used and disclosed.
- How you can get access to information regarding the use of your medical information.
- How you can authorize Wellmark to release your medical information upon approval.
- Or call the customer service number located on your ID card for questions.

Wellmark's internal protection of Personal Health Information

The steps Wellmark has taken to safeguard members' medical information include, but are not limited to:

- Disseminated Notice of Privacy Practices to insured members and posted it on the Wellmark website at Wellmark.com.
- Disseminated a Notice of Privacy Practices and other information practitioners and facilities need to know about Wellmark's privacy practices in the provider newsletter, Blue Ink℠ and on the Wellmark website.
- Established a Privacy Office as a primary point of contact concerning questions or issues regarding privacy matters, including toll-free phone access, email address and published the contact information in the Notice of Privacy Practices on the Wellmark website.
- Established internal policies and procedures for compliance with the Privacy Rule and disseminated the information to employees through corporate-wide privacy training and department-specific training for customer service and other areas.
- As a condition of employment, all members of Wellmark's workforce are required to sign a Confidentiality and Nondisclosure Agreement.
- In daily interaction with members and providers, Wellmark provider and customer service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information.
- Limited physical and information system access to medical information, only people who need this information to perform their jobs have access.
- Strict security regarding access to facility, personal computers and medical information.

General provisions

Eligibility: You are eligible to apply for Wellmark Blue HMO coverage if you reside in the Wellmark Blue HMO service area.

If you are applying for child-only coverage, any child(ren) age 20 and under listed on the application is eligible for child-only coverage or due to a qualifying event that occurs outside of the open enrollment period as long as he/she is not enrolled in or eligible for other coverage[1] at the time of the effective date of coverage.

Premium payment

- Coverage is automatically renewed by payment of your premium and service fee in advance.
- A grace period of 31 days will be granted for the payment of each premium and fees due after the first premium and fees. During this grace period, your benefits policy will continue in force.
- For On-Exchange coverage, a 90-day grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month's premium within the benefit year.
- We may terminate your benefits policy if: (1) you fail to pay your premium when due; (2) there is fraudulent use of your benefits policy; (3) Wellmark terminates or discontinues your plan; or (4) you change your residence from the geographic service area served by Wellmark. You must notify us prior to relocating outside the Wellmark service area, as you will have no benefits for services except for emergencies or accidental injuries.

Subrogation

Once you receive benefits under your Wellmark Blue HMO policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages or any other payment related to that illness or injury. We will assume all rights for recovery, to the extent of our payment, regardless of whether our payment is made before or after settlement of any third-party claim and regardless of whether you have received full or complete compensation for any injury or illness. You and your covered family member(s) agree to notify us if you have the potential right to receive payment from someone else and to cooperate with us to ensure that our rights to subrogation are protected. We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

Coordination of benefits

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

Benefits payable under this benefits policy, when combined with those paid under your other coverage[1] will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount. The method we use to calculate the payment arrangement amount may be different from your other plan's method.

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

Other information

- Premium rates for a specified individual are determined by the base premium rate for the block of business that reflects the actual and anticipated experience for all policies included in the block. Base premium rates are adjusted to reflect the particular benefit plan chosen as well as age, geographic area and tobacco use.

[1] Other coverage includes Group Health coverage or other creditable coverage (not including HIPIOWA, Medicaid or hawk-i)

Health and wellness programs

Helping you maintain or improve your health is important. That's why Wellmark is more than just a health insurance company — we are people helping people. In support of your health care coverage, we provide programs and services with your health and wellness needs in mind. The below programs are not insurance and may be changed or eliminated at any time.

BeWell 24/7® Nurse Support

When you call BeWell 24/7 Nurse Support, you'll be connected with a real person who can help you with a variety of health-related concerns. For example:

- **Locate health care providers and facilities** — whether you're at home or traveling.
- **Estimate your costs** for common medical procedures and services.
- **Coordinate health care appointments,** in-home health help and record retrieval.
- **Discuss treatment options** and answer your health and wellness questions.
- **Make arrangements for community-based services** you or a family member needs like in-home safety modifications, meals, medical equipment, transportation and more.

BeWell 24/7 Nurse Support. It's real help from real people around the clock. Exclusively for Wellmark members. Just call 844-84-BEWELL (239355).

Blue365®

When you become a member of The Blues®, you have access to discounts and services through Blue365, a program designed by the Blue Cross and Blue Shield Association. You can access this program at Wellmark.com/Blue365

You'll find substantial savings and helpful information in these categories:

- **Health and wellness** — referrals and savings on elective procedures, such as laser vision correction surgery, discounts on weight-loss programs and fitness discounts to a network of gyms near you.
- **Family care** — support and information for parents or dependents in need of caregiver services.
- **Financial well-being** — access to help planning for your future.
- **Travel** — discounts on healthy vacations, lodging, destination-specific travel tips and assistance with passport issues and inquiries.

Pregnancy Care program

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

Complex Case Management program

Wellmark's Case Management program is for members with severe or complex health conditions. Members work with clinically trained nurses and social workers who are knowledgeable on unique health situations and able to build personalized care plans.

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

Terms to know

Blue Distinction Center

Blue Distinction Centers (BDCs) are provider facilities that are recognized for their proven expertise in delivering specialty care. These centers have demonstrated their commitment to quality care, resulting in better outcomes for certain types of surgeries. The Blue Distinction® program recognizes providers and hospitals for their expertise and exceptional quality in delivering care, from general health and wellness to more complex and specialty procedures.

Copayments

Specific dollar amounts you pay at the time you receive covered services.

Designated primary care provider (PCP)

Your designated primary care provider evaluates your medical condition and either treats your condition or coordinates services you require. You must choose a primary care provider who participates in the Wellmark Blue HMO network who is available to accept you or your family members and who is one of the following types of providers: family practitioners, general practitioners, geriatricians, internists, nurse practitioners, physician assistants and pediatricians.

Deductible

The fixed dollar amount you pay for most covered services before benefits are available during a benefit period. There are single and family deductibles.

Family deductible

This can be met through any combination of family members. No one member will be required to meet more than the single deductible amount before they receive benefits for a covered service during a benefit period.

Non-formulary drug

A prescription drug that Wellmark's P&T Committee has indicated on the Wellmark Blue Rx Essentials Drug List as Non-Formulary (NF) and not a covered benefit but eligible for an exception request for coverage pursuant to the Exception Requests for Non-Formulary Prescription Drugs.

Out-of-pocket maximum (OPM)

The amount you pay out of your pocket for most covered services during a benefit period. The deductible, copayment and coinsurance provisions, specific to your medical coverage, apply toward meeting the OPM.

Payment arrangement

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

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

- **Network savings** — Reflects the amount you save on a claim by receiving services from a participating or network provider. For the majority of services, the savings reflects the actual amount 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 network provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- **Amount not covered** — Reflects the portion of provider charges not covered under this health plan and for which you are responsible. This amount may include services or supplies not covered, amounts in excess of a service maximum, benefit year maximum, denials for failure to follow a required precertification and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider.
- **Amount paid by health plan** — 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

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 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. Network providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Wellmark Blue HMO network savings

The amount saved due to contracts Wellmark has with providers.

Wellmark Language Assistance

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, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or 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 or phone at:

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

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 ٢٤٢٩-٤٢٥-٠٠٨ أو (خدمة الهاتف النصي: ٨٨٨-١٨٧-٢٦٢٤).

ສ່ວນ ເວົ້າ ໃຈ ໃສ່, ພາ ສາ ລາວ ຖ້າ ທ່ານ ເວົ້າ: ພວກ ເຮົາ ມີ ບໍ ລິ ການ ຄວາມ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ ໃຫ້ ທ່ານ ໂດຍ ບໍ່ ເສຍ ຄ່າ ຫຼື 800-524-9242 ຕິດ ຕໍ່ ທີ. (TTY: 888-781-4262.)

주의: 한국어 를 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 Deitsch 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).

တၢ်နုးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်,ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနဂၢ်လိၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကၢ်.

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: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

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

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif 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 yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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

If you have questions or need additional information:

Please call your agent or Wellmark Health Plan of Iowa, Inc.

Wellmark® Health Plan of Iowa

Wellmark Health Plan of Iowa, Inc.
P.O. Box 9232
Des Moines, IA 50306-9232
Wellmark.com

Wellmark Health Plan of Iowa, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Doctor On Demand by Included Health is a separate company providing an online telehealth solution for Wellmark members. Doctor On Demand® is a registered mark of Included Health, Inc.

PrudentRx is an independent company providing a specialty drug copay card program to Wellmark Blue Cross and Blue Shield members.

© 2026 Wellmark, Inc.

M-9319149 08/26 AN-T