

Notice

The official Plan Document that describes the benefits for which you are eligible under your group health plan is available, in print, in the department of your company responsible for the administration of your benefit plans. A printed copy of a Benefits Certificate further describing benefits for which you are eligible under your group health plan is also available, upon your request, from the department in your company responsible for the administration of your benefit plans.

This notice is attached to an electronic copy of the Benefits Certificate for your group health plan. Wellmark Blue Cross and Blue Shield of Iowa is not responsible for any alterations or modifications that may be made to an electronic copy or other differences that may exist between the attached electronic copy of the Benefits Certificate and the printed Benefits Certificate. Any alterations, modifications, or differences contained in the electronic copy to which this Notice is attached that are not consistent with, or that conflict with, the printed Benefits Certificate issued to your group are not binding on Wellmark Blue Cross and Blue Shield of Iowa. In the event of any inconsistency or conflict between the printed Benefits Certificate and an electronic copy, the terms of the printed Benefits Certificate shall govern.

Benefits Certificate

BlueRxSM Preferred



University of Northern Iowa

Enrollee Rights and Responsibilities

Inspection of Certificate

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

Summary of Payment	1
Important Information	3
Section 1: Benefits	5
Section 2: Drugs Not Covered.....	7
Section 3: Your Payment Obligations	9
Section 4: Filing Claims.....	10
Section 5: Your Certificate.....	13
Glossary	19
Index.....	23

Copayment

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled.

You pay **\$5** each time a covered prescription is filled or refilled for generic drugs.

You pay **\$10** each time a covered prescription is filled or refilled for brand name drugs and branded generic drugs.

Multiple Copayments. Your payment obligations are determined by the quantity of medication you purchase. If you purchase:

- a **30 day** supply of maintenance medication through the CAREMARK mail order drug program, you will be responsible for **one copayment**.
- a **31-90 day** supply of maintenance medication through the CAREMARK mail order drug program, you will be responsible for **two copayments**.

Please note: Federal regulations limit the amount of certain medications that may be dispensed. If your prescription is so regulated, it may not be available in the amount(s) indicated above.

For prescriptions filled at a participating pharmacy, you pay the lesser of the copayment amount or billed charge of the drug.

For prescriptions filled at a nonparticipating pharmacy, you pay the billed charge of the drug at the time you fill your prescription. You will be reimbursed up to the maximum allowable fee of the drug. This may not be full reimbursement for the amount you paid. In addition to your usual payment obligations described earlier in this section, you are responsible for any difference between the billed charge and the maximum allowable fee.

Your total payment obligation depends on whether you use a generic drug. You pay the generic copayment when your prescription is for:

- a drug that has an FDA-approved “A”-rated generic equivalent, and
- your physician has not specified that you must take the brand name drug, and
- you purchase the generic drug.
- a drug that has a generic equivalent, and your physician has not required the brand name drug, but you purchase the brand name drug.

In this last case, in addition to a copayment, you will owe any difference between the billed charge for the brand name drug and the billed charge for the generic. See *Generic Drugs* in *Section 3: Your Payment Obligations*.

As long as your practitioner does not specify the brand name drug, you can fill your prescription with a generic equivalent, and your payment obligation will be less than for the brand name.

You pay the brand name copayment when your prescription is for:

- a drug that has no FDA-approved generic equivalent, or
- a drug that has a generic equivalent, but your physician has specified that you must take the brand name drug.

All copayment amounts assume that:

- the drug is covered under this certificate.
- you buy your prescription at a participating pharmacy.
- you purchase a generic drug when one is available. See *Generic Drugs* in *Section 3: Your Payment Obligations*.

For additional information about your payment responsibilities, see *Section 3: Your Payment Obligations*.

Quantity Limitations

Generally, the maximum quantity of medication you may receive in a single prescription is as follows:

- **Retail Prescriptions:** a 30-day supply.
- **Retail Maintenance Prescriptions:** a 30-day supply.
- **Mail Order Prescriptions:** a 30-day supply.
- **Mail Order Maintenance Prescriptions:** a 90-day supply.

Maintenance is an industry-wide classification for drug treatments to control specific, ongoing health conditions. If you're not sure whether your prescription is for a maintenance drug, call us.

Summary of Payment

Please note: All covered drugs are subject to the quantity limitations above. In addition, benefits for certain drugs are limited by month, benefit period, or lifetime, based on Wellmark's medical necessity criteria. For a list of these limited drugs, visit our website at www.wellmark.com or check with your pharmacist or physician.

Your prescription drug program is called Blue Rx Preferred. It relies on a network of participating pharmacies that contract with Caremark, our pharmacy benefits manager. Participating pharmacies use the Caremark computer information system to verify your enrollment, your benefits, and drug prices.

Using the Blue Rx Preferred Program

You may fill your prescriptions at a retail pharmacy or through the CAREMARK mail order drug program. Electronic claims are processed according to the drug price (average wholesale price or maximum allowable cost) on the records of Caremark on the date your prescription is filled. Claims submitted on paper are processed according to the drug price in effect on the date the claim is processed. See *Section 4: Filing Claims*.

Filling Your Prescription at a Retail Pharmacy

When you need a covered prescription drug, go to a participating pharmacy. To fill a prescription, your pharmacist will need your prescription and your Wellmark Health Plan of Iowa, Inc. identification (ID) card. Your ID card confirms that the pharmacy participates with the network used by this prescription drug program. The ID card also enables the pharmacist to access Caremark's information on:

- your eligibility.
- whether your prescription is a benefit under this certificate.
- the price of the prescription and the amount you are expected to pay.
- generic alternatives.

The Importance of Your ID Card. If you do not have your Wellmark Health Plan of Iowa, Inc. ID card with you when you fill a prescription at a participating pharmacy, the pharmacist will not be able to access your benefit information. In this case:

- You must pay the full billed charge at the time you receive your prescription.
- You must file your claim to be reimbursed. See *Section 4: Filing Claims*.
- We will settle the claim directly with you.
- Your settlement will be for the maximum allowable fee (the amount the pharmacist would have been reimbursed if you had presented your ID card). This means that you may not be reimbursed for the full amount you paid, and you are responsible for any difference between the billed charge and the maximum allowable fee.

If you are unsure whether the pharmacy participates with the network used by this prescription drug program, consult the Blue Rx Preferred directory of participating pharmacies, visit our website at www.wellmark.com, or call us. You can also ask at any pharmacy where you regularly fill your prescriptions whether it is a participating pharmacy.

To ensure that you take full advantage of Blue Rx Preferred, you should:

- tell your practitioner that you are covered by this managed drug program;
- use the same pharmacy for all your prescriptions whenever possible. This gives the pharmacist an opportunity to learn about your medical conditions, allergies, and drug benefits.

What You Should Know About Participating Pharmacies

Pharmacies that participate with the network used by this prescription drug program administer your benefits automatically. When you fill your prescription at a participating pharmacy:

- Caremark has established payment arrangements with participating pharmacies, which may result in savings. You are responsible only for any copayment you may owe, plus any difference between the billed charge for the brand name drug and the billed charge for the generic if you purchase a brand name drug when a generic was available. See the *Summary of Payment* at the beginning of this certificate and *Generic Drugs* in *Section 3: Your Payment Obligations*.
- Participating pharmacies file your claims for you.
- We settle claims directly with participating pharmacies.

Please note: You must present your ID card to the pharmacist in order to receive the above benefits. See *The Importance of Your ID Card*, earlier in this section.

What You Should Know About Nonparticipating Pharmacies

Pharmacies that do not participate with the network used by this prescription drug program will not have your benefit information and cannot administer your benefits. When you fill your prescription at a nonparticipating pharmacy:

- You must pay in full at the time you fill your prescription.
- Caremark does not have contracts with nonparticipating pharmacies, and they do not agree to accept payment arrangements. This means that you may not be reimbursed for the full amount you paid. You are responsible for any difference between the billed charge and the maximum allowable fee. See *Section 3: Your Payment Obligations*.
- Nonparticipating pharmacies are not responsible for filing your claims. See *Section 4: Filing Claims*.
- We settle claims with you and not with nonparticipating pharmacies.

Important Information

Filling Your Prescription Through the CAREMARK Mail Order Drug Program

You can also fill prescriptions through the CAREMARK mail order drug program. The toll-free number for this program is 888-335-1197.

Your Initial Order. The first time you order a prescription, you should:

- complete the mail order drug form. If you did not receive a form, visit our website at www.wellmark.com, or contact us or your group sponsor to request one.
- enclose your completed form, your original prescription(s), and your payment in the envelope provided with the form. You may pay either by credit card or by check. Call the toll-free number to determine your payment amount.

Ordering Refills. You will receive a reorder envelope for future orders. You will also receive a notice of the number of refills remaining (if any) and how to order any authorized refills or new prescriptions.

You will receive your prescription 10 to 14 days following receipt of your order.

Making a Complaint

If you do not agree with a denied claim or a benefit reduction, or if you have a complaint regarding a claim, a provider, or our service, call the toll-free customer service number on your ID card. We will research and try to resolve the complaint in a timely manner.

Understanding This Certificate

It's important that you understand all parts of this managed drug certificate in order to get the most out of your coverage. The words *you* and *your* refer to you and your family members eligible for coverage under this certificate. *We*, *us*, and *our* refer to Wellmark Health Plan of Iowa, Inc.

This certificate outlines the benefits and obligations of this group managed drug program. It is divided into these main sections:

- **Benefits**
- **Drugs Not Covered**
- **Your Payment Obligations**
- **Filing Claims**
- **Your Certificate**
- **Glossary**

Please note: For information on your hospital and other medical benefits, you should consult your health certificate.

Interpreting This Certificate

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

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your certificate. We urge you to become familiar with the entire certificate.

Your Blue Rx Preferred drug program helps you obtain affordable prescription drugs to treat diagnosed illnesses or health conditions. The program contains incentives to help you save money.

Drugs That Are Covered

This program provides coverage for drugs that satisfy all of the following criteria:

- Most prescription drugs (including oral contraceptives) that bear the legend, “Caution, Federal Law prohibits dispensing without a prescription.” Also covered are insulin and these insulin supplies: needles, syringes, test strips, and lancets. **Please note:** If you purchase a covered drug that is subject to a state sales tax, we will cover the amount of the tax.
- Drugs prescribed by a practitioner who is legally authorized to prescribe.
- Drugs dispensed by a pharmacist from a licensed retail pharmacy or from the CAREMARK mail order drug program.
- Drugs that are medically necessary for your condition. Unless otherwise required by law, we decide what is medically necessary and our decision is final and conclusive. Even though your practitioner may recommend a drug, the recommendation doesn’t always mean the drug is medically necessary. Medically necessary means that a covered drug is all of the following:
 - Medically suited and necessary for the symptoms, diagnosis, and direct treatment of your illness, injury, or health condition.
 - Consistent with professionally recognized standards of health care and given at the right time and in the right setting.
 - Not primarily for your convenience or the convenience of your provider.
 - The most appropriate drug or quantity of drug that can safely be provided.
 - Enables you to make reasonable progress in treatment.If alternative drugs and procedures meet medical necessity criteria for the diagnosis and treatment of your condition and are substantially equal in clinical effectiveness, we reserve the right to approve the least costly alternative.
- Drugs purchased outside the United States are covered only if all the following are true:
 - You are injured or become ill while in a foreign country.
 - The drug is FDA-approved or an FDA equivalent and has the same name as the FDA-approved drug.
 - The drug would require a written prescription by a licensed M.D. or D.O. if prescribed in the U.S.
 - You provide acceptable documentation that you received a covered service from a physician or

hospital and the physician or hospital prescribed the drug.

You are not covered for drugs administered by injection with the exception of insulin, Imitrex, and EpiPen. All drugs must be self-administered according to the instructions given by the practitioner and the pharmacist.

Wellmark Drug List

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

The Wellmark Drug List is subject to change. For current information on the Wellmark Drug List, visit our website at www.wellmark.com.

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

To determine if a drug is on the Wellmark Drug List, check with your physician or pharmacist or visit our website at www.wellmark.com.

Prior Authorization

Certain drugs are covered by this certificate only with prior authorization. The prior authorization process allows us to verify that the drug is part of a specific treatment plan and is medically necessary. Without prior authorization for these drugs, you are responsible for paying the entire billed charge. For a list of these limited drugs, visit our website at www.wellmark.com or check with your pharmacist or physician.

We will respond to a request for prior authorization within 72 hours in a medically urgent situation or within 15 days in a non-urgent situation. We ordinarily respond at the time a call is received; however, calls received after 4:00 p.m. are considered the next business day.

To get prior authorization for your prescription:

- Your practitioner should provide us with the authorization information at the phone number listed in the materials he or she has received. If we authorize the prescription, and you present your ID card to the pharmacist, any pharmacy that participates with the network used by this prescription drug program will be able to fill your prescription according to your benefits.
- If your practitioner does not provide us with the prior authorization information and you fill your prescription

Section 1: Benefits

at a pharmacy that participates with the network used by this prescription drug program, the pharmacist should contact us or the prescribing practitioner. This prior authorization process may result in some delay in filling your prescription. Encouraging your practitioner to complete the prior authorization process ahead of time can avoid delays.

If you fill your prescription at a pharmacy that does not participate with the network used by this prescription drug program, submit your claim to us. See *How to File in Section 4: Filing Claims*. If your Explanation of Health Care Benefits indicates that your prescription drug claim has been denied because you did not obtain prior authorization, follow the appeal process described under *Appealing a Denied Claim in Section 4: Filing Claims*.

Prior Authorization for Noncovered Drugs. Prior authorization also may allow a drug that is not normally covered to be covered if it is part of a specific treatment plan and medically necessary.

You or your practitioner must request prior authorization by calling or writing our customer service department with the following information:

- the reason the drug should be covered; and
- the length of time the drug should be covered.

Right of Appeal. You have the right to one full and fair review in case of an adverse decision in response to a prior authorization request. An adverse decision is one that denies or reduces benefits. You (or your authorized representative, if you have designated one) may appeal an adverse decision. For information on authorizing another person to represent you, see *Authorized Representative in Section 5: Your Certificate*.

You may appeal by calling the toll-free phone number on your ID card or by writing within 180 days from the date of the notice of our decision to:

Wellmark Health Plan of Iowa, Inc.
Health Management Department
636 Grand Avenue, Station 017
Des Moines, IA 50309-2565

Appeal Procedure. We will review your request once. You must submit all relevant information with your initial request. You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the adverse decision whether or not presented or available at the initial determination.

The review will be conducted by someone different from the original decision makers and without deference to the

original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Notification of Decision. In a medically urgent situation, we will notify you of our decision within 72 hours after receipt of your request for appeal. In non-urgent situations, we will notify you of our decision within 30 days after receipt of your request for appeal.

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

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider may request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

Refills

You may not receive benefits for a refill if:

- sufficient time has not elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- the refill is to replace medications that have been lost, damaged, stolen, or used inappropriately.
- the refill is to be used by someone other than for whom the prescription was written.
- the refill is in excess of the number authorized by the practitioner.
- the refill is limited by state law.

Please note: You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time. If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this benefits certificate. See *Quantity Limitations* in the *Summary of Payment* section. If traveling outside the United States, the refill amount will not exceed a 90-day supply. To receive authorization for an early refill, have your pharmacist call us.

This Blue Rx Preferred certificate does not provide benefits for certain categories of drugs. Drugs are not covered by this certificate if they are administered and billed by a hospital, practitioner, home health agency, or any other duly authorized professional besides a pharmacist at a licensed retail pharmacy or through the CAREMARK mail order drug program. If you have Wellmark Health Plan of Iowa, Inc., health coverage, some of the following exclusions may be covered under your health certificate.

Birth Control and Fertility

Infertility Drugs. You are not covered for prescription drugs necessary to treat male or female infertility.

Subcutaneous Implants. You are not covered for subcutaneous implants such as Norplant.

Covered by Other Programs or Laws

Governmental Programs. You are not covered for prescription drugs when you are entitled to claim benefits from governmental programs (except Medicaid).

Payment Responsibility. You are not covered for prescription drugs when someone else has the legal obligation to pay for your care, and when, in the absence of this certificate, you would not be charged.

Workers' Compensation Reimbursement. You are not covered for services or supplies that are compensated under the workers' compensation laws, including any services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under the workers' compensation laws if you had complied with such laws' requirements relating to notice of injury, timely filing of claims, and medical treatment authorizations. This exclusion does not apply to the treatment of complications resulting from small pox vaccinations when payment for such treatment is not available through government-sponsored programs.

Miscellaneous

Chemical or Tobacco Dependency. You are not covered for prescription drugs used to treat chemical or tobacco dependency.

Convenience Packaging. You are not covered for prescription drugs in convenience packaging when the cost exceeds the cost of the drug when purchased in its normal container.

Cosmetic Drugs. You are not covered for prescription drugs that are primarily to improve your natural appearance.

Drugs Administered by Injection. You are not covered for drugs administered by injection with the exception of insulin, Imitrex, and EpiPen.

Drugs You Abuse. You are not covered for drugs determined to be abused or otherwise misused by you.

Effective Date. You are not covered for prescription drugs that you receive before the effective date of coverage under your certificate.

Growth Hormones. You are not covered for growth hormones.

Immunization Agents. You are not covered for drugs used as immunization agents, or biological products for allergy immunization, or biological serum, blood, blood plasma, and other blood products or fractions.

Impotence. You are not covered for drugs for the treatment of impotence unless it is the result of a physical illness or injury.

Investigational or Experimental Drugs. You are not covered for prescription drugs that are considered investigational or experimental. Drugs are considered investigational or experimental when the drug has progressed to limited human application but has not achieved recognition from the Food and Drug Administration as being proven and effective in clinical medicine. To determine whether a drug is considered investigational or experimental, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association. These criteria include whether a drug is:

- recognized as having received final governmental regulatory approval for a specific diagnosis;
- scientifically recognized as being effective in improving health outcomes for a specific diagnosis; and
- at least as beneficial and no more expensive than any reasonable alternative for a specific diagnosis.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual for consideration by all Blue Cross and Blue Shield member organizations. While Wellmark Health Plan of Iowa, Inc., may apply and rely on the evaluation criteria in this reference manual, the final decision remains solely in the discretion of our Medical Director, whose decision may include reference to, but is not controlled by policies or decisions of other member organizations. Copies of the evaluation criteria and reference manual for a specific drug are available upon request.

Irrigation Solutions and Irrigation Supplies. You are not covered for irrigation solutions or supplies.

Nutritional Supplements. You are not covered for prescription nutritional dietary supplements. This includes supplementary vitamin preparations, minerals, herbal products, and multivitamins. This exclusion does not apply to prescription prenatal vitamins.

Over-the-Counter. You are not covered for most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a

Section 2: Drugs Not Covered

physician may be covered. To determine if a particular over-the-counter product is covered, call the toll-free customer service number on your ID card.

Self-help or Self-cure Drugs. You are not covered for self-help or self-cure drugs.

Therapeutic Devices or Medical Appliances. You are not covered for therapeutic devices or medical appliances including hypodermic needles or syringes and home/durable medical equipment. This exclusion does not apply to needles and syringes for insulin.

Weight Reduction Drugs. You are not covered for weight reduction prescription drugs whether or not weight reduction is medically appropriate.

This section explains payment vocabulary, how your drug benefit amounts are determined, and your cost-sharing payment obligations.

This section covers:

- Payment Vocabulary
- Amounts You Pay to Share Costs

Payment Vocabulary

Billed Charge

The billed charge is the retail price for a covered prescription drug at the pharmacy at which you fill your prescription.

Maximum Allowable Fee

The maximum allowable fee is the amount payable for covered drugs that we establish, using various methodologies and data, such as the average wholesale price.

Payment Arrangements

Caremark has established payment arrangements with participating pharmacies that may result in savings. If you fill your prescription at a nonparticipating pharmacy, you may not be reimbursed for the full amount you pay to the nonparticipating pharmacy. In addition to your usual payment obligations as described in the *Summary of Payment* at the beginning of this certificate, you are responsible for any difference between the billed charge and the maximum allowable fee.

Drug Company Rebates

Drug manufacturers offer rebates to pharmacy benefits managers such as Caremark. Wellmark receives a share of these rebates from Caremark. Any rebates we receive will be retained by Wellmark and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your payment obligations.

Amounts You Pay to Share Costs

The amounts of your cost-sharing obligations and specific contract maximums are shown on the *Summary of Payment* at the beginning of this certificate.

Copayment

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled.

Please note: If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for any difference between the billed charge for the brand name drug and the billed charge for the generic. See *Generic Drugs* later in this section.

Generic Drugs

The cost of your drug coverage is based on the assumption that you will use an FDA-approved “A”-rated generic drug whenever available. This is a prescription drug with active therapeutic ingredients chemically identical to a brand name drug. If you choose a brand name drug when a suitable generic is available, you are responsible for your copayment plus any difference between the billed charge for the brand name drug and the billed charge for the generic.

There are certain exceptions when you may use a brand name drug without owing this difference:

- When the FDA does not rate an available generic substitute for the prescribed drug as “A”-equivalent.
- When very small changes in the dosage level could cause toxic results. Drugs of this class are called narrow therapeutic index drugs.
- When your practitioner specifies that a generic substitute is not allowed and that the drug must be dispensed as written.

Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, our pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

Section 4: Filing Claims

You must file a claim for prescription drugs you purchase from a nonparticipating pharmacy. You also must file a claim for prescription drug purchases for which you have paid in full, if you think the purchase(s) should have been a covered benefit. As long as you present your ID card to the pharmacist, you do not need to file a claim when you purchase a covered prescription drug from a participating pharmacy.

This section explains:

- **The Claim Filing Process**
- **Filing When You Have Other Coverage**
- **Appealing a Denied Claim**

The Claim Filing Process

How to File

All claims must be submitted in writing and follow the procedures in this section. All claims must be received within 365 days after the end of the calendar year you fill a prescription. If you need a claim form or have any questions after reading this section, please contact your personnel department, or call us.

Complete all Sections. You must complete all sections of the claim form. Directions are printed on the back of the form. You should keep a copy of the claim for your records because no part of it can be returned to you. You should follow the same procedure for filing a claim for services received in- or out-of-state or out-of-country.

Separate Claim Forms by Family Member and Pharmacy. You must complete a separate claim form for each family member and for each pharmacy you use. A maximum of three prescriptions for the same family member and the same pharmacy is acceptable per claim form. Please use additional claim forms for submitting more than three prescriptions, or if the prescriptions are for more than one family member or pharmacy. We recommend that you tape receipts to the back of the claim form in the spaces provided. Please do not use staples.

Send Your Claims to:

Caremark
P.O. Box 853901
Richardson, TX 75085-3901

Notification of Decision. We will send an Explanation of Health Care Benefits following your claim. In case of an

adverse decision, the notice will be sent within 30 days of receipt of the claim. We may extend this time by up to 15 days if the claim determination is delayed for reasons beyond our control. If we do not send an explanation of benefits statement or a notice of extension within the 30-day period, you have the right to begin an appeal. We will notify you of the circumstances requiring an extension and the date by which we expect to render a decision. If an extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied.

Reimbursement Amount

Since the Blue Rx Preferred drug program is based on payment arrangements with contracting pharmacies, you may not be reimbursed for the full amount you paid if:

- you fill your prescription at a nonparticipating pharmacy, or
- you fail to present your ID card when you fill your prescription at a participating pharmacy.

In addition to your usual payment obligations as described in the *Summary of Payment* at the beginning of this certificate, you are responsible for any difference between the billed charge and the maximum allowable fee.

Filing When You Have Other Coverage

Coordination of Benefits

You may have other insurance or coverage that provides the same or similar benefit(s) as this certificate. If so, the benefits payable under this certificate when combined with the benefits paid under your other coverage will not be more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

Please note: The method we use to calculate our payment arrangement amount may be different from your other carrier's method. For a description of how we determine our payment arrangement amount, see *Payment Arrangements* in *Section 3: Your Payment Obligations*.

What You Should Do. When you submit a claim for services, you must inform us that you have other coverage and whether that other coverage has provided benefits. Other coverage includes: group insurance; other group benefit plans (such as HMOs, PPOs, and self-insured programs); Medicare and other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis). To help us coordinate your benefits, you should indicate that you have other coverage and whether that other coverage has provided benefits when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

You must cooperate with us and provide requested information about your other coverage. Failure to provide information can result in a denied claim.

If you know that your other coverage has the primary responsibility for payment, submit a claim first to the other carrier. If the claim is processed with an unpaid balance for eligible benefits under this certificate, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payments. We may contact your provider or the other carrier for further information.

Rules of Coordination. There are certain rules we follow to help us determine which coverage pays first when other coverage provides the same or similar benefits as this certificate. Here are some of the rules:

- The coverage without coordination of benefits pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The medical coverage of your auto insurance pays before this coverage if the auto insurance does not have a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans.
- The coverage that you have as an employee or plan enrollee pays before the coverage you have as a spouse/domestic partner or dependent child.
- The coverage that you have as the result of active employment (neither laid off nor retired) pays before coverage you have as a laid off or retired employee.
- The coverage with the earliest continuous effective date pays first when none of the above rules apply.

If none of these rules apply to your situation, we will use the Coordination of Benefits guidelines adopted by the Iowa Insurance Division to determine our settlement amount.

Dependent Children. To coordinate benefits for a dependent child, the following rules apply. For a child who is:

- covered by both parents who are not separated or divorced, or if they are and neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.
- covered by separated or divorced parents and a court decree says which parent has financial or health insurance responsibility, that parent's coverage pays first.
- covered by both separated or divorced parents and a court decree does not stipulate which parent has financial or health insurance responsibility, then the coverage of the parent with custody pays first. The

payment order for such a dependent child is as follows: custodial parent, spouse of custodial parent, other parent, or spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

When You Present Your ID Card. Notwithstanding the foregoing section on *Coordination of Benefits*, Wellmark will always pay as though it is the primary carrier when you present your Wellmark ID card to the pharmacist at the point of sale.

Appealing a Denied Claim

Appeal Procedure

In the event that we deny a claim in whole or in part, you have a right to one full and fair review. You (or your authorized representative, if you have designated one) may request that we review a denied claim. For information on authorizing another person to represent you, see *Authorized Representative* in *Section 5: Your Certificate*.

Your request to review a claim must be made within 180 days from the claim denial. We will respond to your request within 60 days of receiving it. You must file your request in writing addressed to:

Wellmark Health Plan of Iowa, Inc.
Appeals
636 Grand Avenue, Station 52
Des Moines, IA 50309-2565

We will review your request once. You must submit all relevant information with your initial request. Your request must include:

- Date of your request.
- Your printed name and address (and name and address of the authorized representative if you have designated one).
- Identification number and claim number from your Explanation of Health Care Benefits.
- Date of service in question.
- Name and phone number of the pharmacy where your claim was denied.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

You may submit written comments, documents, or other information in support of your appeal. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all

Section 4: Filing Claims

information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone different from the original decision makers and without deference to the original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

You shall not start legal action against us until you have exhausted this appeal procedure.

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

External Review

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider may request an external review of our decision through the Iowa Commissioner of Insurance. Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

Our responsibilities to you, as well as the conditions of your coverage with us, are defined in the documents that make up your contract. Your contract includes any application you submitted to us or to your employer or group sponsor, any agreement or group policy we have with your employer or group sponsor, any application completed by your employer or group sponsor, this benefits certificate, and any riders or amendments.

This section explains:

- Coverage Eligibility
- Coverage Changes
- Coverage Termination
- Our Right to Recover Payments
- Other Information

Coverage Eligibility

Eligible Enrollees

An eligible enrollee is an employee who has met the employer's eligibility requirements and the employee's spouse/domestic partner or eligible dependent child(ren).

An eligible dependent child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. Dependent children must meet the following requirements:

- The child is not married and either under 19 years of age or a full-time student (for a definition of *full-time student*, see the *Glossary* at the end of this certificate); or
- The child is totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student, and the child must have had continuous creditable coverage without a break of 63 days or more since on or before the child turned age 19 or while the child was a full-time student.

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

Medicare Eligibility

If you become eligible for Medicare for any reason, you must notify your employer or group sponsor immediately. If you are eligible for this coverage other than as a current employee or a current employee's spouse, your eligibility for Medicare may terminate your coverage under this certificate. Also see *Coverage Continuation Under Federal Law—COBRA* later in this section.

Types of Coverage

There are different categories of coverage you may hold under this certificate.

- With single coverage, the plan enrollee is the only one covered.
- With family coverage, the plan enrollee, his or her spouse/domestic partner, and each of his or her eligible, dependent children have coverage. Each covered family member must be listed on the plan enrollee's application or added later as a new enrollee.

Qualified Medical Child Support Order (QMCSO)

If you have a dependent child and your employer or group sponsor receives a Medical Child Support Order recognizing the child's right to enroll in this health benefit plan, your employer or group sponsor will promptly notify both you and the dependent that the order has been received. Your employer or group sponsor also will inform you and the dependent of the employer's procedures for determining whether the order is a Qualified Medical Child Support Order.

To be a Qualified Medical Child Support Order, the Medical Child Support Order must clearly specify:

- your name and last known mailing address, if any;
- the name and mailing address of the dependent specified in the court order;
- a reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined;
- the period to which the order applies.

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

Within 20 days of receiving the order, your employer or group sponsor will decide whether the court order is a Qualified Medical Child Support Order and will notify you and the dependent of that determination.

Once your employer or group sponsor decides that a court order is a Qualified Medical Child Support Order, the order is binding on both the employer and us, meaning that the

Section 5: Your Certificate

dependent is eligible to enroll under the applicable terms and conditions of the plan as well as our standard enrollment guidelines. Your employer or group sponsor must allow enrollment of the dependent regardless of any enrollment season restrictions that normally apply. Also, your employer or group sponsor must forward a copy of the order to us and ask that we enroll the dependent in the plan.

Within 40 days of our receipt of either the order or the application, whichever comes first, we will decide whether the dependent is eligible for enrollment and will notify your employer or group sponsor of the dependent's eligibility status. Your employer or group sponsor has the authority to enroll you in a plan if necessary to enroll the dependent. If your employer or group sponsor offers more than one plan, your employer or group sponsor will enroll the dependent in the same plan in which you are enrolled. If you are eligible for a plan, but not enrolled, the Iowa Department of Human Services will select a plan for the dependent. If you are eligible for a plan but not enrolled, and the order is received from a child support agency of another state, that agency shall select a plan for the dependent.

The dependent's eligibility for and enrollment in the plan will be governed by all applicable terms and conditions, including, but not limited to, eligibility standards. If eligible, the dependent will receive the same coverage that you do and will be allowed to enroll immediately regardless of normal enrollment procedures. Your employer or group sponsor will withhold your share, if any, of the dependent's health care premiums from your compensation and forward this amount to us.

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

Within 20 days of receiving the order, your employer or group sponsor must tell both you and the dependent that:

- the dependent has been enrolled in a health benefit plan; or
- the dependent is ineligible for enrollment and why; or
- the order has been forwarded to us without a determination of the dependent's eligibility.

If the dependent enrolls in a health benefit plan, your employer or group sponsor will provide all the following information to you and the dependent:

- The name of the insurer providing the health benefit plan.
- The dependent's effective date of coverage.
- The health benefit plan or account number.

- The type of health benefit plan under which the dependent has been enrolled, including whether dental, vision, office visits, and prescription drugs are covered services.
- A brief description of the applicable deductibles, coinsurance, waiting periods for preexisting conditions, and other significant terms or conditions materially affecting the coverage.

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

If your employer or group sponsor decides that the order is not a Qualified Medical Child Support Order, each dependent specified in the order as entitled to enroll in the health benefit plan may submit a written appeal to your employer or group sponsor. Within 30 days of receiving the appeal, your employer or group sponsor will respond in writing.

Your employer or group sponsor may not revoke enrollment or eliminate coverage for a dependent unless your employer or group sponsor has received satisfactory written evidence of any of the following conditions:

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

Your employer or group sponsor is not required to maintain coverage for the dependent if:

- You are no longer paying premiums because your employer or group sponsor no longer owes you compensation; or
- You have terminated employment with the employer and have not elected to continue coverage.

When Coverage Begins

Your coverage under this certificate begins on your effective date. If you have just started a new job, check with your employer or group sponsor to find out your effective date.

Please note: Before you receive benefits under this certificate, you have agreed in your application (or in documents kept by us or your employer or group sponsor) to release any necessary information requested about you so we can process claims for benefits. You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you fraudulently use your certificate or misrepresent or conceal material facts in your application, then we may terminate this certificate.

When Coverage Ends

Your eligibility for coverage will terminate at the end of the month your employment terminates for any of the following reasons:

- You become unemployed.
- You become ineligible for coverage under this certificate. *See Eligible Enrollees* earlier in this section.
- Your employer or group sponsor decides to discontinue coverage or replaces this coverage.
- The number of individuals covered under this group plan is fewer than the number or percentage of eligible individuals required to be covered.
- We receive written notice from your employer requesting termination of coverage.
- We decide to terminate coverage of all similar certificates by giving written notice to your employer or group sponsor 90 days prior to termination.

We shall notify you in writing at least 30 days before the termination date and provide a statement of reason for the termination, if we terminate your coverage for any of the following reasons:

- You use this certificate fraudulently or you fraudulently misrepresent or conceal material facts in your application, or your employer or group sponsor commits fraud or makes an intentional misrepresentation of a material fact under the terms of this certificate. If this happens, we will recover any claims payments we made, minus any premiums paid.
- You leave the Wellmark Health Plan Network service area for more than a four-month period of time (except full-time college students).
- You or your employer or group sponsor fail to make payments to us when due.
- You unreasonably refuse to follow a prescribed course of treatment.
- You fail to meet your employer's eligibility requirements.

Please note: We stop payment for any services or supplies the day the certificate is terminated.

Authority to Terminate, Amend, or Modify.

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

Continued Coverage

There are some federal and state laws that may affect your coverage with us. These laws apply to continuing your

coverage when you are no longer eligible for group coverage.

Coverage Continuation Under Federal Law—COBRA.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and your eligible dependents to continue coverage under this certificate if coverage is lost due to certain qualifying events such as your termination from employment, a divorce, or loss of dependent status. You and your eligible dependents will be required to pay for any continuation coverage. There are other federal or state laws similar to COBRA that may apply if COBRA does not apply. Additional information regarding continuation coverage will be provided to you by your employer or group sponsor.

Premiums

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

If you make an intentional misrepresentation of a material fact under the terms of this certificate, the monthly premiums for this coverage will be retroactively adjusted as if the material fact had been disclosed in the application for coverage.

Coverage Changes

Events Changing Coverage

Certain events may require or allow you to change who is covered by this certificate. These events include:

Adding Members Due to Special Enrollment Events.

The following events allow you as well as a spouse/domestic partner or any eligible children to enroll for coverage:

Birth, Adoption, or Placement for Adoption.

Exhaustion of COBRA Coverage.

Marriage.

Spouse or Dependent Loses Eligibility for Creditable Coverage or his or her employer or group sponsor ceases contribution to creditable coverage.

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

Addition of a Natural Child by Court Order.

Appointment as a Legal Guardian of a child.

Care of a Foster Child (when placed in your home by an approved agency).

Dependent resumes full-time student status.

Section 5: Your Certificate

Removing Family Members Due to Special Enrollment Events. The following events require you to remove the affected family member(s) from your coverage:

Active Military Service.

Completion of Full-time Schooling of a dependent.

Death.

Dependent Child who is not a full-time student or permanently disabled reaches 19 years of age.

Divorce, Annulment, or Legal Separation.

Eligibility for Medicare (see earlier in this section under *Medicare Eligibility*).

Marriage of a dependent child.

Notification of Change

You must notify your employer or group sponsor within 31 days of the date of the event that changes the coverage status of enrollees who are covered under this certificate.

Please note: If you fail to provide notification of an event that requires you to change coverage, your coverage under this benefits certificate may terminate.

Authorized Certificate Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this certificate. This certificate cannot be changed except by:

- written amendment signed by an authorized officer and accepted by you or your employer or group sponsor as shown by payment of the premium.
- our receipt of proper notification that an event has changed your spouse/domestic partner or dependent's eligibility for coverage, as described under *Events Changing Coverage*. See *Types of Coverage* explained earlier in this section.

Coverage Termination

Effects of Termination

If your certificate is terminated for fraud, misrepresentation, or the concealment of material facts:

- we will not pay for any services or supplies provided after the date the certificate is terminated.
- we will retain legal rights. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.
- we may, at our option, declare the certificate void.

If your certificate is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we will stop benefits the day your certificate is terminated.

Our Right to Recover Payments

Subrogation

Once you receive benefits under this certificate arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury. We will assume all rights of 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. This provision includes benefits from any of the following:

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

You and your family agree to all of the following:

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

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

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

Workers' Compensation

If you have received benefits under this certificate for an injury or condition which is the subject or basis of a workers' compensation claim (whether or not litigated), we are entitled to reimbursement to the extent of benefits paid under this certificate either from your employer, its

workers' compensation carrier or you in the event your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, we are entitled to reimbursement from you to the extent of benefits paid under this certificate out of any proceeds you receive in settlement of any workers' compensation claim regardless of whether the settlement is a compromise or disputed settlement and regardless of any characterization of the settlement proceeds by the parties to the settlement.

We utilize industry standard methods to identify claims which may be the result of work related injuries. This may result in some initial claims that are the result of work related injuries being paid. We reserve the right to seek reimbursement of any such claims or to waive the right to seek reimbursement on any specific claim, in our sole discretion.

Payment in Error

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

Other Information

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at www.wellmark.com or by calling Customer Service. In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

Notice

If a specific address has not been provided elsewhere in this certificate, you may send any notice to our home office:

Wellmark Health Plan of Iowa, Inc.
636 Grand Avenue
Des Moines, IA 50309-2565

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

Confidentiality and Release of Information

We are committed to protecting the privacy of your health information. We will request, use, or disclose your health information only as permitted or required by law. For example, we will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations. **Please note:** Wellmark has issued a *Privacy Practices Notice*. This notice is available upon request or at www.wellmark.com.

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

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

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

Other Disclosures. We will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, at your request we may release claim payment information to a friend or family member to act on your behalf during a hospitalization by submitting an authorization to release information to that person.

Nonassignment

Benefits for covered services in this certificate are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign this certificate or rights to payment without our consent will be void.

Governing Law

To the extent not superseded by the laws of the United States, this certificate will be construed in accordance with

Section 5: Your Certificate

and governed by the laws of the state of Iowa. Any action brought because of a claim under this certificate will be litigated in the state or federal courts located in the state of Iowa and in no other.

Legal Action

You shall not start any legal action against us unless you have exhausted the applicable appeal process and the external review process described in *Section 4: Filing Claims*.

You shall not bring any legal or equitable action against us because of a claim under this certificate, or because of the alleged breach of this certificate, more than two years after the end of the calendar year in which the services or supplies were provided.

Enrollee Contribution

Your employer or group sponsor determines the amount you may be required to pay for your health care coverage. For additional information about contributions to your health care coverage, please contact your personnel department.

Information if You or a Member of Your Family is Enrolled in Medicaid

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

Enrollment Without Regard to Medicaid. Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this plan, nor will it affect our determination of any benefits paid to you.

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

Benefit Period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1.

Billed Charge is the retail price for a covered prescription drug at the pharmacy at which you fill your prescription.

Blue Rx Preferred means this prescription drug program you have through Wellmark Health Plan of Iowa, Inc.

Brand Name Drug is a prescription drug patented by the original manufacturer. Usually, after the patent expires, other manufacturers may make FDA-approved generic copies. Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, our pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

Branded Generic Drug means a substitute prescription drug with the same active chemical ingredients as a brand name drug. It may be treated as a brand name drug throughout the industry for one of the following reasons:

- It is not made under the original patent, but the manufacturer traditionally makes brand name drugs instead of generics; or
- The drug's price is not significantly lower than that of the brand name drug.

Caremark is our pharmacy benefits manager. Caremark owns the network, the network of participating pharmacies used by Blue Rx Preferred.

Contract includes any application you submitted to us or your employer or group sponsor, any agreement or group policy we have with your employer or group sponsor, any application completed by your employer or group sponsor, this benefits certificate, and any riders or amendments.

Coordination of Benefits (COB) applies when you are covered by more than one group contract or insurance policy providing benefits for like services. COB is a method of limiting benefits to no more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled. See the *Summary of Payment* at the beginning of this certificate.

Covered Drugs means those prescription drugs that are a benefit under this certificate.

Creditable Coverage means any of the following types of coverage that you, the enrollee, had without a break in coverage of 63 days or more:

- A group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Part A or B of Title XVIII of the Social Security Act (Medicare).
- Title XIX of the Social Security Act (Medicaid).
- Chapter 55 of Title 10, United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A State health benefits risk pool.
- A health plan offered under Chapter 89 of Title 5, United States Code (Federal Employee Health Benefit Plan).
- A public health plan (as defined in regulations).
- A health benefit plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

Dependent Child means your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. To be eligible for coverage, the child must be unmarried and either under 19 years of age, a full-time student, or totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 19 or while the child was a full-time student, and the child must have had continuous creditable coverage without a break of 63 days or more since on or before the child turned age 19 or while the child was a full-time student. A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted shall be eligible for coverage as of the date of placement for adoption or the date of actual adoption, whichever occurs first.

Domestic Partner means your unmarried, same-sex domestic partner as defined by your employer or group sponsor.

Effective Date is the date upon which this certificate goes into effect.

Enrollee means any person who is covered under this certificate.

Family Coverage means coverage for the plan enrollee and his or her eligible family members.

Family Member means any member of a plan enrollee's family (including the plan enrollee) covered under this certificate.

Fertility Drugs promote conception.

Full-time Student is a dependent claiming status as a full-time student. The dependent must be enrolled in an accredited institution of higher learning, such as a college, university, nursing school, or trade school, and must be considered full-time as defined by the institution in which the dependent is enrolled. Full-time student status continues during:

- regularly scheduled school vacation periods; and
- absence from class (in which enrolled) for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.

Generic Drug means a prescription drug rated by the Food and Drug Administration as “A”-equivalent to a brand name drug. It has active therapeutic ingredients chemically identical to a brand name drug. Also see *brand name drug* and *branded generic drug*.

Group is made up of those plan enrollees who share a common relationship such as employment or membership.

Group Sponsor is the entity that sponsors this group insurance arrangement as permitted by Iowa law under which the plan enrollee is eligible and applied for this group certificate.

Home Health Agency (HHA) is a Medicare-approved or Joint Commission for the Accreditation of Health Care Organizations (JCAHO) approved agency or organization that provides skilled nursing care in your home.

Home/Durable Medical Equipment is an item that meets the following criteria:

- It is durable enough to withstand repeated use.
- It is primarily and customarily manufactured to serve a medical purpose.
- It is not useful in the absence of illness or injury.

Examples include wheelchairs, walkers, and crutches.

Hospital means an institution that provides for the diagnosis, treatment, or care of injured or sick persons. The facility must be licensed as a hospital under applicable law.

Identification Card is a card issued to you by us. The information on the card, especially the identification number, is required to process your claims correctly and answer questions you may have. You should carry your identification card with you at all times and present it to your pharmacy at the time you fill your prescription.

Immunization is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

Investigational or Experimental Drugs are drugs that have progressed to limited human application but have not achieved recognition as being proven and effective in clinical medicine. Criteria include whether a drug is:

- recognized as having received final governmental regulatory approval for a specific diagnosis;
- scientifically recognized as being effective in improving health outcomes for a specific diagnosis; and
- at least as beneficial and no more expensive than any reasonable alternative for a specific diagnosis.

These criteria are considered by the Blue Cross and Blue Shield Association’s Medical Advisory Panel in publishing a Reference Manual for consideration by all member organizations. While we may apply the evaluation criteria in this reference manual, the final decision remains in the discretion of our Medical Director. (See *Section 2: Services Not Covered*.)

Limitation is a certain condition placed on a covered drug that limits coverage.

Maintenance is an industry-wide classification for drug treatments to control specific, ongoing health conditions.

Maximum Allowable Fee means the amount payable for covered drugs that we establish, using various methodologies and data, such as the average wholesale price.

Medical Appliances mean devices or mechanisms designed to:

- support or restrain part of the body such as a splint, bandage, or brace;
- measure the functioning or physical condition of the body such as glucometers or devices to measure blood pressure;
- administer drugs such as syringes.

Medical Child Support Order (MCSO) means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction that:

- provides for child support with respect to a plan enrollee’s child or a child of the plan enrollee’s spouse or provides for health benefits coverage to such a child, is made pursuant to a State domestic relations law, and relates to benefits under the health benefit plan of the plan enrollee; or
- enforces a law relating to medical child support described in Iowa Code Chapter 252E (2001) or Section 1908 of the Social Security Act with respect to a group plan.

Medically Necessary means a prescription drug that we consider eligible for benefits under this certificate and is all of the following:

- Medically suited and necessary for the symptoms, diagnosis, and direct treatment of your illness, injury, or health condition.
- Consistent with professionally recognized standards of health care and given at the right time and in the right setting.
- Not primarily for your convenience or the convenience of your provider.
- The most appropriate drug or quantity of drugs that can safely be provided.
- Enables you to make reasonable progress in treatment.

If alternative drugs and procedures meet medical necessity criteria for the diagnosis and treatment of your condition and are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

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

Nonparticipating Pharmacy means a pharmacy that does not contract with Caremark.

Oral Contraceptives prevent conception.

Our means Wellmark Health Plan of Iowa, Inc.

Over-the-Counter Drugs are Food and Drug Administration (FDA) approved drugs that can be purchased without a prescription.

Participating Pharmacy means a pharmacy that contracts with Caremark.

Pharmacist means someone licensed to dispense drugs.

Physician means a medical doctor (M.D.) or a doctor of osteopathy (D.O).

Placement for Adoption means you assume a legal obligation to provide full or partial support of a child you intend to adopt.

Plan Enrollee means you, the person who signed for this certificate.

Practitioner is a health care professional licensed to prescribe drugs and other medication.

Prescription Drugs mean drugs and medicines that:

- require a written prescription from your health care practitioner;
- are dispensed by a licensed pharmacist from a licensed pharmacy; and
- bear the legend, “Caution, Federal Law prohibits dispensing without a prescription.”

Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes a specified person’s right to enroll in the health benefit plan for which the plan enrollee or his/her dependents are eligible. A QMCSO includes the following information:

- The name and last known mailing address (if any) of the plan enrollee and the name and mailing address of each person specified in the order as entitled to enroll in the group health plan;
- A reasonable description of the type of coverage to be provided or the manner in which the type of coverage is to be determined;
- The period to which the order applies.

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

Refills mean when a physician allows or orders continued use of the same medication for the same illness or condition. Medications cannot be refilled until 75 percent of the prescription has been used when taken according to the instructions given by the prescribing physician.

Single Coverage means coverage for the plan enrollee only.

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa.

Subcutaneous Implant is a medication that is surgically placed beneath the skin to release the drug into the bloodstream.

Subrogation means our rights when you or your family members receive benefits of this certificate required as the result of illness or injury and you have a lawful claim against another party or parties for compensation, damages, or other payment.

Termination Date is the date your coverage ends under this certificate.

Therapeutic Devices—See *Medical Appliances*.

Glossary

Us means Wellmark Health Plan of Iowa, Inc.

We means Wellmark Health Plan of Iowa, Inc.

Weight Reduction Drug is primarily designed to assist in weight reduction or is prescribed to assist in weight reduction even though the drug is generally used for other purposes.

Wellmark Drug List contains drugs physicians recognize as being medically effective for a wide range of health conditions.

You and Your means you and your family members eligible under this certificate.

A

A equivalent drugs9
 adopted child 13, 15
 adoption 15
 annulment 16
 appeals 11

B

billed charge9
 birth control7
 birth of a child 15
 brand name drugs 1, 3, 9

C

chemical dependency.....7
 child support order..... 13
 children 13
 claim form 10
 claims..... 11
 COBRA 15
 complaints..... 11
 convenience packaging7
 coordination of benefits 10
 copayment..... 1, 9
 cosmetic drugs7
 coverage begins 14
 coverage changes..... 15
 coverage continuation 15

D

death 16
 dependent children..... 13, 16
 dependents 15
 disabled child 13
 divorce 16
 drug abuse.....7
 drugs9

E

eligibility for coverage..... 13
 experimental drugs7

F

family coverage 13

Federal Law 15
 fertility.....7
 filing claims 10
 foster child 13, 16
 full-time student 13, 16

G

generic drugs9
 governing law 18
 governmental programs7
 grievances 11
 growth hormones7

I

Imitrex5
 immunization agents.....7
 implants7
 infertility drugs7
 insulin5
 insulin supplies5
 investigational drugs.....7
 irrigation supplies8

L

legal guardian 13, 16

M

mail order drugs..... 1, 4
 maintenance drugs 1
 marriage 15
 maximum allowable fee9
 maximum quantity 1
 Medicaid 18
 medical appliances.....8
 Medical Child Support Order 13
 medical necessity2
 Medicare eligibility 13
 military service 16

N

name brand drugs 1, 3, 9
 nonparticipating pharmacies3
 nutritional supplements8

Index

O		
oral contraceptives	5	
out-of-country	10	
out-of-state	10	
over-the-counter drugs	8	
P		
participating pharmacies	3	
payment arrangements	9	
payment in error	17	
premiums	15	
prenatal vitamins	8	
prior authorization	5	
Q		
Qualified Medical Child Support Order	13	
quantity limitations	1	
R		
refills	6	
		reimbursement
		10
S		
self-help or self-cure drugs	8	
separation	16	
smoking cessation	8	
spouse	13, 15	
stepchild	13	
student	16	
subcutaneous implants	7	
subrogation	16	
T		
termination of coverage	15, 16	
therapeutic devices	8	
tobacco dependency	7	
types of coverage	13	
W		
weight reduction drugs	8	
Workers' Compensation	7	