Wellmark Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

Amendment to Your Coverage Manual

This amendment to your coverage manual is effective January 1, 2012, except as noted otherwise. The headings refer to sections in the coverage manual. Please review this amendment and keep it with your coverage manual.

Alliance Select

At a Glance - Covered and Not Covered

The following language is deleted from your coverage manual.

In certain instances Wellmark will pay a provider an episode of care rate for all covered services received in a single episode of care (e.g., a hospital stay or an outpatient visit). When a provider is paid an episode of care rate, benefits will be applied to the entire episode of care and not to the individual service(s) received.

This may result in payment for a particular claim exceeding the service maximum listed for a particular covered service, and you will not be responsible for amounts in excess of the service maximum for that episode of care. However, the service maximum for that service will be applied to any subsequent episodes of care that occur during the benefit year.

Details – Covered and Not Covered

Dental Services

You are covered for orthodontic services required for surgical management of cleft palate.

Home Skilled Nursing

The description of home skilled nursing is deleted and replaced with the following.

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

Speech Therapy

The description of speech therapy coverage is revised.

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

Not Covered:

- Speech therapy services not provided by a licensed or certified speech pathologist.

- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

Vision Services

The eye exercises exclusion is deleted. Orthoptic eye exercises may be covered if medically necessary.

Blue Rx Preferred

Insulin Supplies

You are covered for diabetic supplies.

Nutritional and Dietary Supplements

You are not covered for fish oil products.

Alliance Select

Choosing a Provider

BlueCard Program

The description of the BlueCard Program is deleted and replaced with the following.

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 Iowa or South Dakota, 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 PPO providers throughout the United States. Participating providers have a contractual agreement with the Blue Cross or Blue Shield Plan in their home state ("Host Blue"). The Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

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

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

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

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

When you receive covered services from BlueCard providers outside the Wellmark service area, you are responsible for notification requirements.

Notification Requirements and Care Coordination

Precertification

The description of precertification is deleted and replaced with the following.

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. Precertification is required; however, it does not apply to maternity or emergency services.
Applies to	Acute Rehabilitation Facility Services Home Health Services Nursing Facility Services Facilities Outside Iowa or South Dakota, excluding maternity or emergency services.
Person Responsible	PPO providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for precertification if: ■ You are admitted to a nonparticipating facility outside Iowa or South Dakota; ■ You receive any of the services listed above from a participating or nonparticipating provider.
Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. Requests without adequate supporting information may be denied if documentation is not provided within 48 hours of the initial request.

Importance	If you choose to receive any service subject to precertification and we determine that the procedure was not medically necessary, you will be responsible for the charges. If we determine the procedure is medically necessary and otherwise covered, without precertification, benefits will be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed $500 per admission. You are subject to this benefit reduction only if you (instead of your provider) are responsible for notification. Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum.

Notification

A new notification requirement is added to your coverage.

Purpose	Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.
Applies to	Home Infusion Therapy Hospice Services Inpatient Admissions, except for: — Maternity stays up to 48 hours for normal labor and delivery or up to 96 hours for cesarean delivery. Maternity stays longer than 48 hours for normal delivery or 96 hours for cesarean delivery are subject to notification.
Person Responsible	PPO providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf are responsible for notification if: ■ You are admitted to a nonparticipating facility outside Iowa or South Dakota; ■ You receive any of the services listed above from a participating or nonparticipating provider.
Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services.

Prior Approval

The description of prior approval is deleted and replaced with the following.

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under this medical benefits plan. Before you receive certain services, prior approval is recommended.
Applies to	For a complete list of the services subject to prior approval, visit *www.wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	PPO providers request prior approval for you. You are responsible for prior approval if you receive the care from a participating or nonparticipating provider.
Process	When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form. Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies. Requests without adequate supporting information may be denied if documentation is not provided within 48 hours of the initial request.
Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and service maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, it may not be covered. Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits plan in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or a new medical benefits plan), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended. **Note:** If prior approval is recommended, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See *Precertification* and *Notification* earlier in this amendment.

Concurrent Review

Continued Stay Review is deleted and replaced with Concurrent Review.

Purpose	Concurrent review is a utilization review conducted during a member's facility stay or course of treatment at home or in a facility setting to determine whether the place or level of service is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	Acute Rehabilitation Facility Services Home Skilled Nursing Inpatient Admissions Nursing Facility Services
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary. Concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage. Requests that do not include supporting information may be denied for lack of information, if documentation is not provided within 48 hours of initial request.
Importance	Wellmark may require a change in the level or place of service in order to continue providing benefits. If we determine that your current facility setting or level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.

Factors Affecting What You Pay

The description of Benefit Year is revised.

Benefit Year

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

How Coinsurance is Calculated – BlueCard PPO Providers Outside the Wellmark Service Area

The description of how coinsurance is calculated for services received by BlueCard PPO Providers Outside the Wellmark Service Area is revised.

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

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Copayments.
  - Amounts representing any general exclusions and conditions.

Often, the negotiated price will be a simple discount that reflects an actual price the Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

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

Nonparticipating Providers

The description of our maximum payment for services received by nonparticipating providers outside Iowa or South Dakota is revised. When you receive services from these providers:

You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by a nonparticipating provider will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from nonparticipating providers.

Coordination of Benefits

Coordination of benefits provisions for your Blue Rx Preferred prescription drug plan are revised with the following addition to Rules of Coordination.

Rules of Coordination

When you present your Blue Rx Preferred ID card to a pharmacy as the primary payer, the benefits of your Blue Rx Preferred prescription drug plan are primary for prescription drugs purchased at the pharmacy. If the benefits of your Blue Rx Preferred prescription drug plan are secondary and you present

your Blue Rx Preferred ID card to a pharmacy as the secondary payer, the benefits of your Blue Rx Preferred prescription drug plan are secondary for prescription drugs purchased at the pharmacy.

Appeals

The appeal procedure described in your coverage manual is deleted and replaced with the following.

Right of Appeal

You have the right to one full and fair review in the case of an adverse benefit determination that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim, or an adverse benefit determination concerning a pre-service notification requirement. Pre-service notification requirements are:

- A precertification request.
- A notification of admission or services.
- A prior approval request.
- A prior authorization request for prescription drugs.

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *www.wellmark.com*.

Medically Urgent Appeal

To appeal an adverse benefit determination involving a medically urgent situation, you may request an expedited appeal, either orally or in writing. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision.

Non-Medically Urgent Appeal

To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

What to Include in Your Internal Appeal

You must submit all relevant information with your appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

For a prescription drug appeal, you also must submit:

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

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

Where to Send Internal Appeal

Medical or Prescription Drugs

Wellmark Blue Cross and Blue Shield of Iowa
Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232

Review of Internal Appeal

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

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

Decision on Internal Appeal

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

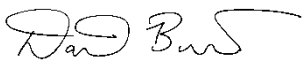
Medically Urgent Appeal

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

All Other Appeals

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

All other terms and provisions of your coverage manual, including any amendments we may have issued previously, remain unaltered and in effect.



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