THE UNIVERSITY OF IOWA

UISELECT

HIGHLIGHTS OF PLAN PROVISIONS, COVERED SERVICES AND PROVIDERS

ABOUT THIS SUMMARY

The benefits information presented in this summary does not constitute official plan documents. Additional terms and conditions apply. If there are any discrepancies between the information contained herein and the official plan documents, the plan documents will govern.

Contents

Plan Provisions

UISelect Providers by Level

LEVEL 1	LEVEL 2	LEVEL 3
All UI Health Care Locations including: • UI Hospitals & Clinics • UI Urgent Care • UI QuickCare	Providers in the Blue Access network	**Not covered, except in emergencies.** (Dependent children attending college, long-term travelers, and families living apart may be covered through guest membership)

PLAN PROVISIONS	LEVEL 1	LEVEL 2
DEDUCTIBLE	Employee: $400 Family: $800	Employee: $800 Family: $1,600
INPATIENT CARE DEDUCTIBLE	See Deductible Above	See Deductible Above
COINSURANCE	15%	25%
COPAY	Primary Care: $10 copay Specialists: $20 copay	Primary Care: $35 copay Specialists: $50 copay
OUT-OF-POCKET MAXIMUM	Employee: $2,000 Family: $3,400	Employee: $3,000 Family: $6,000
PREVENTIVE CARE	$0 copay	$0 copay
DOC ON DEMAND	$0 copay	$0 copay
UI QUICKCARE	$5 copay	N/A
OFFICE VISITS	Primary Care: $10 copay Specialists Care: $20 copay	Primary Care: $35 copay Specialists Care: $50 copay
REHABILITATION SERVICES (office billed physical, speech & occupational therapies and chiropractic care)	$10 copay	$35 copay
MENTAL HEALTH CARE VISITS	$10 copay	$10 copay
URGENT CARE	$10 copay	$35 copay
EMERGENCY ROOM VISITS	$100 copay followed by 10% coinsurance *(copay waived if admitted)*	$100 copay followed by 10% coinsurance *(copay waived if admitted)*

Prescription Drugs

Plan Formulary Name:

- Blue Rx Value Plus (UISelect)

To review Wellmark Blue RX Value Plus formulary drug list, please visit Wellmark.com. Scroll down and choose the specific drug plan link you wish to access and enter the name of the drug in the top left-hand corner to begin your search.

Note: Formulary Drug Lists are best viewed in Chrome.

Pharmacy Program Plan	**UISelect Blue Rx Value Plus**
Tier 1 Generic Drugs	$0 copay
Tier 2 Name-brand drugs	30% coinsurance
Tier 3 Name-brand, non-formulary drugs	50% coinsurance
Tier 4 Name-brand, non-formulary drugs	N/A
Annual Pharmacy Out-of-Pocket Maximum	Employee: $1,100 Family: $2,200

*For specific services, please visit section titled **Covered and Not Covered**.

Provider Network

Under the medical benefits of this plan, your network of providers consists of UISelect Wellmark Blue Access providers. All other providers are not in your network. Which provider type you choose will affect what you pay.

Benefit Levels

Your UISelect medical program allows you to use University-related and Blue Access network providers you choose. Where you access care affects what you pay.

Benefit Level 1 applies when you receive services from these providers:

All UI Health Care locations including:

- University of Iowa Hospitals & Clinics
- UI Urgent Care
- UI QuickCare

Benefit Level 2 applies when you receive services from a Wellmark Blue Access Network Provider.

Benefit Level 3 is closed, except in the case of an emergency or guest membership for dependent children attending college, long-term travelers, and families living apart.

Payment Details

Deductible

This is the fixed dollar amount you pay for covered health care services before your plan begins to pay. The deductible may not apply to all services. Once you meet the deductible, then coinsurance applies. Deductible amounts are waived for some services.

Copay

This is a fixed dollar amount that you pay each time you receive certain covered services.

Emergency Room Copay

The emergency room copay:

- applies to emergency room services
- is followed by coinsurance
- is taken once per facility per date of service
- is waived if you are admitted as an inpatient of a facility immediately following emergency room services

Office Visit Copay

The office visit copay:

- applies to covered office exams received from a Wellmark Blue Access Provider
- is taken once per practitioner per date of service

Other Copay

The other copay:

- applies to all office services in UI QuickCare clinics
- is taken once per practitioner per date of service

Telehealth Services Copay

The telehealth services copay:

- applies to covered telehealth exams received from Wellmark Blue Access practitioners
- is taken once per practitioner per date of service.
- This is for “other” telehealth services outside of Doctor on Demand

Urgent Care Center Copay

The urgent care center copay:

- applies to covered urgent care services received from Benefit Level 1 or 2 providers in Iowa classified by Wellmark as Urgent Care Centers
- is taken once per practitioner per date of service

Mental Health Copay

The mental health copay:

- applies to covered mental health/chemical dependency services from Wellmark Blue Access practitioners
- is taken once per practitioner per date of service.

Coinsurance

Coinsurance is an amount you pay for certain covered services.

Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section by either Wellmark's payment arrangement amount or by the amount charged for a service. The calculation method differs depending on the service you receive, on the contracting status of the provider and/or the state where you receive services. Coinsurance amounts apply after you meet the deductible and any applicable copays.

Coinsurance amounts are waived for some services.

Out-of-Pocket Maximum

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

These amounts include:

- Deductible
- Coinsurance
- Emergency room copays
- Office visit copays
- Other copays
- Telehealth services copays
- Urgent care center copays
- Emergency care and approved Guest Membership deductible, copays and coinsurance when received from an Out-of-Network provider who *IS* participating with Blue Cross/Blue Shield

Out-of-pocket maximum amounts you pay for Benefit Level 1 and Emergency Care apply toward meeting the Level 1 out-of-pocket maximum.

Out-of-pocket maximum amounts you pay for Benefit Level 2 and Guest Membership services apply toward meeting the Benefit 2 out-of-pocket maximum.

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

The out-of-pocket maximum aggregates for Level 1 and 2.

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

- Amounts representing any general exclusions and conditions.
- Difference in cost between the provider's amount charged and the maximum allowable fee when you receive services from an Out-of-Network provider who is NOT participating with Blue Cross/Blue Shield.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

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

Benefits Maximums

Benefits maximums are the maximum benefit amounts that each member is eligible to receive. Benefits maximums are accumulated from benefits under this medical benefits plan and prior medical benefits plans sponsored by the University of Iowa and administered by Wellmark Health Plan of Iowa, Inc. Benefits maximums accumulate from benefits provided at Benefit Level 1 or 2.

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Breast pumps (manual or electric purchased from a covered Wellmark Blue Access home/durable medical equipment provider. **Please note:** When hospital-grade breast pumps are purchased from a covered Network home/durable medical equipment provider, only copay is waived.	Deductible Coinsurance Copay
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding when received from Wellmark Blue Access.	Deductible Coinsurance Copay
Contraceptive medical devices, such as intrauterine devices and diaphragms received from Wellmark Blue Access.	Deductible Coinsurance Copay
Immunizations	Deductible Coinsurance Copay
Implanted and injected contraceptives received from Wellmark Blue Access providers.	Deductible Coinsurance Copay
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines when received from Wellmark Blue Access providers. Counseling will be limited to 8 visits annually.	Deductible Coinsurance Copay
Newborn's initial hospitalization, when considered normal newborn care – facility services received from Wellmark Blue Access providers.	Deductible
Physician services related to maternity care received at Benefit Level 1 or 2.	Deductible Coinsurance Copay
Independent laboratory services received at Benefit Level 1 or 2.	Deductible
Postpartum home visit (one) when a mother and her baby are voluntarily discharged from the hospital within 48 hours of normal labor and delivery or within 96 hours of cesarean birth.	Deductible Coinsurance
Preventive care, items, and services, received from Wellmark Blue Access as follows: • Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; • Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and • Preventive care and screenings for women provided for in guidelines supported by the HRSA.	Deductible Coinsurance Copay

Covered Service (continued)	Payment Obligation Waived
Preventive digital breast tomosynthesis (3D mammogram) when received from Wellmark Blue Access or Participating providers.	Deductible Coinsurance Copay
Preventive prostate-specific antigen (PSA) testing.	Deductible Coinsurance Copay
Services subject to office visit copay amounts.	Deductible Coinsurance
Services subject to other copay amounts.	Deductible Coinsurance
Services subject to urgent care center copay amounts.	Deductible Coinsurance
Telehealth services.*	Deductible Coinsurance
Voluntary sterilization for female members received from Wellmark Blue Access or Participating providers.	Deductible Coinsurance Copay
Well-child care.	Deductible Coinsurance Copay

*Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through myWellmark.com.

Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained in the coverage manual.

The headings in this chart provide the following information:

Category: Service categories are listed alphabetically and are repeated, with additional detailed information, in *Details – Covered and Not Covered*.

Covered: The listed category is generally covered, but some restrictions may apply.

Not Covered: The listed category is generally not covered.

Benefits Maximums: This column lists maximum benefit amounts that each member is eligible to receive. Benefits maximums that apply per benefit year or per lifetime are reached from benefits accumulated under this group health plan and any prior group health plans sponsored by the University of Iowa and administered by Wellmark Health Plan of Iowa, Inc. **Please note** Benefits maximums accumulate for medical and prescription drug benefits separately.

Category	Covered	Not Covered	Benefits Maximums
Acupuncture Treatment		✗	
Allergy Testing and Treatment	✓		
Ambulance Services	✓		
Anesthesia	✓		
Autism Treatment	✓		
Blood and Blood Administration	✓		
Breast Tomosynthesis (3D Mammogram)	✓		
Chemical Dependency Treatment	✓		
Chemotherapy and Radiation	✓		
Clinical Trials – Routine Care Associated with Clinical Trials	✓		
Contraceptives	✓		
Cosmetic Services	✓		
Counseling and Education Services		✗	
Dental Treatment for Accidental Injury	✓		
Dialysis	✓		
Education for Diabetes and Nutrition	✓		10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to two hours annually.
Dental Treatment for Accidental Injury	✓		

(Covered and Not Covered continued)

Category	Covered	Not Covered	Benefits Maximums
Emergency Services	✓		
Fertility and Infertility Services	✓		$15,000 per lifetime for covered services and supplies related to infertility treatment.
Genetic Testing	✓		
Hearing Services	✓		$2,000 during every five consecutive year period for hearing aids and hearing aid evaluation, testing and repairs. Routine hearing exams are covered one per benefit period.
Home Health Services	✓		The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services.
Home/Durable Medical Equipment (DME)	✓		
Hospice Services	✓		15 days per lifetime for inpatient hospice respite care. 15 days per lifetime for outpatient hospice respite care. **Please note:** Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	✓		
Illness or Injury Services	✓		
Imaging and Laboratory Services	✓		
Inhalation Therapy	✓		
Maternity Services	✓		
Medical Evacuation	✓		
Medical and Surgical Supplies and Personal Convenience Items	✓		
Mental Health Services	✓		
Morbid Obesity Treatment	✓		
Motor Vehicles		✗	
Musculoskeletal Treatment	✓		
Nonmedical or Administrative Services		✗	
Nutritional and Dietary Supplements	✓		
Occupational Therapy	✓		
Orthotics		✗	
Physical Therapy	✓		
Physicians and Practitioners			
Advanced Registered Nurse Practitioners	✓		
Audiologists	✓		

Category	Covered	Not Covered	Benefits Maximums
Physicians and Practitioners cont. Chiropractors	✓		
Doctors of Osteopathy	✓		
Licensed Independent Social Workers	✓		
Medical Doctors	✓		
Occupational Therapists	✓		
Optometrists	✓		
Oral Surgeons	✓		
Physical Therapists	✓		
Physician Assistants	✓		
Podiatrists	✓		
Psychologists	✓		
Speech and Hearing Practitioners at Wendell Johnson Clinic	✓		
Speech Pathologists	✓		
Platelet-Rich Plasma Injections	✓		
Prescription Drugs	✓		
Preventive Care	✓		One preventive physical exam (includes separate female gyn exam and pap smear) and one preventive mammogram per benefit period are covered.
Prosthetic Devices	✓		
Reconstructive Surgery	✓		
Repatriation	✓		
Self-Help Programs		✗	
Sleep Apnea Treatment	✓		
Social Adjustment		✗	
Speech Therapy	✓		
Surgery	✓		
Telehealth Services	✓		
Temporomandibular Joint Disorder (TMD)	✓		
Transplants	✓		
Transplant Lodging Costs		✗	
Vision Services	✓		
Wigs or Hairpieces		✗	

Covered and Not Covered Descriptions

All covered services or supplies listed in this section are subject to the general contract provisions and limitations. If a service or supply is not specifically listed, do not assume it is covered.

Acupuncture Treatment

- × **Not Covered:** Acupuncture and acupressure treatment.

Allergy Testing and Treatment

- ✓ **Covered.**

Ambulance Services

- ✓ **Covered:** Professional emergency air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

- × **Not Covered:**
  - × Professional air or ground ambulance transport from a facility capable of treating your condition.
  - × Non-emergency air or ground transport including, but not limited to, non-emergency air or ground transportation when performed primarily for your convenience or the convenience of your family, physician or other health care provider.

Anesthesia

- ✓ **Covered:** Anesthesia and the administration of anesthesia.

- × **Not Covered:** Local or topical anesthesia billed separately from related surgical or medical procedures.

Autism Spectrum Disorder Treatment

- ✓ **Covered:** Diagnosis and treatment of autism spectrum disorder. Autism spectrum disorder is a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior.

- × **Not Covered:**
  - × Applied Behavior Analysis services for the treatment of autism spectrum disorder for members age 21 and older.
  - × Applied Behavior Analysis services other than for the treatment of autism spectrum disorder.

Blood and Blood Administration

- ✓ **Covered:** Blood and blood administration, including blood derivatives, and blood components.

Breast Tomosynthesis (3D Mammogram)

- ✓ **Covered:** Breast tomosynthesis (3D mammogram).

Chemical Dependency Treatment

- ✓ **Covered:** Treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs or alcohol.

- × **Not Covered:** Education, training, and activity therapy if services are not part of an outpatient program for treatment of mental health or chemical dependency at the University of Iowa Hospitals & Clinics.

Chemotherapy and Radiation Therapy

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

Contraceptives

- ✓ **Covered:** The following conception prevention, as approved by the U.S. Food and Drug Administration:
  - ✓ Contraceptive medical devices, such as intrauterine devices and diaphragms.
  - ✓ Implanted contraceptives.
  - ✓ Injected contraceptives.

  Please note: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches are covered under your Blue Rx Value Plus prescription drug benefits.

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

Cosmetic Services

- ✓ **Covered:** Cosmetic services, supplies, or drugs only if provided primarily to restore function, lost or impaired, as the result of an illness, accidental injury, or a birth defect.

  Benefits Maximum:
  - ✓ *Restorative dental services required as the result of an accidental injury must be received within 18 months following the date of accident.*

- × **Not Covered:** Cosmetic services, supplies, or drugs provided primarily to improve physical appearance. You are not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

Counseling and Education Services

- × **Not Covered:**
  - × Bereavement counseling or services (including volunteers or clergy), family counseling or training services, marriage counseling or training services, and community-based services.
  - × Education or educational therapy other than covered lactation consultant services, education for self-management of diabetes, or nutrition education.
  - × Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for the treatment of obesity, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia, for any medical, mental health, or substance abuse condition.

Dental Services

- ✓ **Covered:**
  - ✓ Dental treatment for accidental injuries when:
    - Treatment is completed within 12 months of the injury.
    - Follow-up treatment for any cosmetic repairs related to the accidental injury must be completed within 18 months.
  - ✓ Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
    - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or

- Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.

✓ Surgical removal of impacted teeth is covered as an inpatient or outpatient, but only with a concurrent medical condition. Inpatient removal is covered only when you have a medical condition (such as hemophilia) that requires hospitalization.

✓ Facial bone fracture reduction.

✓ Incisions of accessory sinus, mouth, salivary glands, or ducts.

✓ Jaw dislocation manipulation.

✓ Orthodontic services associated with management of cleft palate.

✓ Treatment of abnormal changes in the mouth due to injury or disease of the mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:

- Dental services related to medical transplant procedures;
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system); or
- Treatment of neoplasms of the mouth and contiguous tissue.

× **Not Covered:**

× General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or management of cleft palate.

× Injuries associated with or resulting from the act of chewing.

× Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

Dialysis

✓ **Covered:** Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes and Nutrition

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

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

✓ Outpatient training or education must be provided by a state-certified program.

✓ The state-certified diabetic education program helps any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.

✓ You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your nutritional requirements.

✓ Nutrition education is appropriate for, but not limited to:

✓ Glucose intolerance.
✓ High blood pressure.
✓ Lactose intolerance.
✓ Morbid obesity.

Benefits Maximum:

✓ **10 hours** of outpatient diabetes self- management training provided within a 12-month period, plus follow-up training of up to two hours annually.

Emergency Services

- ✓ **Covered:** When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:
  - ✓ Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
  - ✓ Serious impairment to bodily function; or
  - ✓ Serious dysfunction of any bodily organ or part.

  In an emergency, if you cannot reasonably reach a Wellmark Blue Access Provider, covered services will be reimbursed as though they were received from a Wellmark Blue Access Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

Fertility and Infertility Services

- ✓ **Covered:**
  - ✓ Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
  - ✓ Infertility testing and treatment for infertile members including in vitro fertilization, gamete intrafallopian transfer (GIFT), and pronuclear stage transfer (PROST).
  - ✓ The collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in connection with fertility or infertility procedures; freezing of sperm, oocytes, or embryos.
  - ✓ Reversal of a tubal ligation (or its equivalent) or vasectomy.

  Benefits Maximum:
  - ✓ **$15,000** per lifetime for covered services and supplies related to infertility treatment.

- × **Not Covered:**
  - × Surrogate parent services.

Genetic Testing

- ✓ **Covered:** Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:
  - ✓ You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
  - ✓ The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

Hearing Services

- ✓ **Covered:**
  - ✓ Routine hearing examinations.
  - ✓ Hearing aids.

  Benefits Maximum:
  - ✓ Routine hearing examinations are covered one per benefit period.
  - ✓ **$2,000** during every five consecutive year period for hearing aids and hearing aid evaluation, testing and repairs.

Home Health Services

- ✓ **Covered:** All of the following requirements must be met in order for home health services to be covered:
  - ✓ You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
  - ✓ Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
  - ✓ Services are prescribed by a physician and approved by Wellmark for the treatment of illness or injury.
  - ✓ Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
  - ✓ The care is referred by a Wellmark Blue Access Provider and approved by Wellmark.
- × **Not Covered:**
  - × Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are:
    - × assistance in walking and getting in and out of bed;
    - × aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions;
    - × preparation of special diets;
    - × and supervision of medication that can usually be self-administered.
  - × You are also not covered for sanitaria care or rest cures.

Home/Durable Medical Equipment

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

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

Hospice Services

- ✓ **Covered:** Care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice care covers the same services as described under *Home Health Services*, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO). Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital.

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

Hospitals and Facilities

- ✓ **Covered:** Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:
  - ✓ **Ambulatory Surgical Facility.** This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed and must be licensed as an ambulatory surgical facility under applicable law.
  - ✓ **Chemical Dependency Treatment Facility.** This type of facility must be licensed as a chemical dependency treatment facility under applicable law.
  - ✓ **Community Mental Health Center.** This type of facility provides treatment of mental health conditions and must be licensed as a community mental health center under applicable law.
  - ✓ **Hospital.** This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.
  - ✓ **Nursing Facility.** This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis for short-term care. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver. The facility must be licensed as a nursing facility under applicable law.
  - ✓ **Residential Treatment Facility.** This type of facility provides treatment for severe, persistent, or chronic mental health conditions or chemical dependency that meets all of the following criteria:
    - Treatment is provided in a 24-hour residential setting.
    - Treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision.
    - Treatment includes training in basic skills such as social skills and activities of daily living.
    - Treatment does not require daily supervision of a physician.
  - ✓ **Psychiatric Medical Institution for Children (PMIC).** This type of facility provides inpatient psychiatric services to children and is licensed as a PMIC under Iowa Code Chapter 135H.

    Precertification is required.

- × **Not Covered:**
  - × Long Term Acute Care Facility.
  - × Treatment received in an Out-of-Network residential treatment facility.

Illness or Injury Services

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

  Treatment may be received from an approved provider in any of the following settings:
  - ✓ Home.
  - ✓ Inpatient (such as a hospital or nursing facility).
  - ✓ Office (such as a doctor's office).
  - ✓ Outpatient.
- × **Not Covered:**
  - × Long term acute care services typically provided by a long-term acute care facility.
  - × Routine foot care, including related services or supplies, except as described under *Covered*.

Imaging and Laboratory Services

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

Inhalation Therapy

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

Maternity Services

- ✓ **Covered:** Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

  Please note: You must notify us or The University of Iowa if you enter into an arrangement to provide surrogate parent services

  In accordance with federal or applicable state law, maternity services include a minimum of:

  - ✓ 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery, or
  - ✓ 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

  A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

  If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

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

Medical Evacuation

- ✓ **Covered:** Medical evacuation services if you become ill or have an injury at a location where adequate medical care cannot be provided. The medical evacuation generally will be to the nearest adequate medical facility. If you are from outside the United States, medical evacuation may be either to the nearest adequate medical facility or to your home country. This benefit applies to the employee, spouse, domestic partner, or child covered under this medical benefits plan.

Medical and Surgical Supplies and Personal Convenience Items

- ✓ **Covered:** Medical supplies and devices such as:
  - ✓ Dressings and casts.
  - ✓ Oxygen and equipment needed to administer the oxygen.
  - ✓ Diabetic equipment and supplies including insulin syringes purchased from a covered home/durable medical equipment provider.

Medical and Surgical Supplies and Personal Convenience Items (continued)

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

Mental Health Services

- ✓ **Covered:** Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient or by telephone consultation. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers. To qualify for mental health treatment benefits, the following requirements must be met:
  - ✓ The disorder is classified as a mental health condition in the *Diagnostic and Statistical* Manual of Mental Disorders, Fifth Edition (DSM-V) or subsequent revisions.
  - ✓ The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of *International Classification of Diseases; Clinical Modification* used for diagnosis coding.
- × **Not Covered:** Treatment for:
  - × Certain disorders related to early childhood, such as academic underachievement disorder.
  - × Communication disorders, such as stuttering and stammering.
  - × Education, training, and activity therapy if services are not part of an outpatient program for treatment of mental health or chemical dependency at the University of Iowa Hospitals & Clinics.
  - × Impulse control disorders.
  - × Conditions that are not pervasive developmental and learning disorders.
  - × Sensitivity, shyness, and social withdrawal disorders.
  - × Sexual disorders.
  - × Treatment received in an Out-of- Network residential treatment facility.

Morbid Obesity Treatment

- ✓ **Covered:** Weight reduction surgery provided the surgery is medically necessary for your condition. Not all procedures classified as weight reduction surgery are covered.
- × **Not Covered:**
  - × Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

Motor Vehicles

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

Musculoskeletal Treatment

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

- × **Not Covered:** Massage therapy.

Nonmedical or Administrative Services

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

Nutritional and Dietary Supplements

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

- × **Not Covered:** Other prescription and non- prescription nutritional and dietary supplements including, but not limited to:
  - × Herbal products.
  - × Fish oil products.
  - × Medical foods, except as described under *Covered*.
  - × Minerals.
  - × Supplementary vitamin preparations.
  - × Multivitamins.

Occupational Therapy

- ✓ **Covered:** Occupational therapy services are covered when all the following requirements are met:
  - ✓ Services are to treat the upper extremities, which means the arms from the shoulders to the fingers.
  - ✓ The goal of the occupational therapy is improvement of an impairment or functional limitation.
  - ✓ The potential for rehabilitation is significant in relation to the extent and duration of services.
  - ✓ The expectation for improvement is in a reasonable (and generally predictable) period of time.
  - ✓ There is evidence of improvement by successive objective measurements whenever possible.

- × **Not Covered:**
  - × Occupational therapy supplies.
  - × Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
  - × Occupational therapy performed for maintenance.
  - × Occupational therapy services that do not meet the requirements specified under *Covered*.

Orthotics

- × **Not Covered:** Orthotic foot devices such as arch supports or in-shoe supports, elastic supports, orthopedic shoes, or examinations to prescribe or fit such foot devices, supports, or shoes, and orthotics training.

Physical Therapy

- ✓ **Covered:** Physical therapy services are covered when all the following requirements are met:
  - ✓ The goal of the physical therapy is improvement of an impairment or functional limitation.
  - ✓ The potential for rehabilitation is significant in relation to the extent and duration of services.
  - ✓ The expectation for improvement is in a reasonable (and generally predictable) period of time.
  - ✓ There is evidence of improvement by successive objective measurements whenever possible.
- × **Not Covered:**
  - × Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
  - × Physical therapy performed for maintenance.
  - × Physical therapy services that do not meet the requirements specified under *Covered*.

Physicians and Practitioners

- ✓ **Covered:** Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:
  - ✓ **Advanced Registered Nurse Practitioners (ARNP).** An ARNP is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.
  - ✓ **Audiologists.**
  - ✓ **Chiropractors.**
  - ✓ **Doctors of Osteopathy (D.O.)**
  - ✓ **Licensed Independent Social Workers.**
  - ✓ **Medical Doctors (M.D.).**
  - ✓ **Occupational Therapists.** This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.
  - ✓ **Optometrists.**
  - ✓ **Oral Surgeons.**
  - ✓ **Physical Therapists.**
  - ✓ **Physician Assistants.**
  - ✓ **Podiatrists.**
  - ✓ **Psychologists.** Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register.
  - ✓ **Speech and Hearing Practitioners at Wendell Johnson Clinic.**
  - ✓ **Speech Pathologists.**

Platelet-Rich Plasma Injections

- ✓ **Covered:** Platelet-rich plasma injections, including image guidance, harvesting, and preparation when performed.

Prescription Drugs

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

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

of these drugs, visit our website at *Wellmark.com* or check with your pharmacist or physician.

Prescription drugs and medicines covered under your medical benefits include:

- ✓ **Drugs and Biologicals.** Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.
- ✓ **Intravenous Administration.** Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).
- ✓ **Specialty Drugs.** Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They are not available through the mail order drug program.

  Specialty drugs may be covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits. To determine whether a particular specialty drug is covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card. ***Specialty drugs are covered only if dispensed by the UI Health Care Pharmacy.**

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

- × Antigen therapy.
- × Medication Therapy Management (MTM) when billed separately.
- × Drugs purchased outside the United States failing the requirements specified earlier in this section.
- × Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.
- × Prescription drugs that are not FDA- approved.

Preventive Care

✓ **Covered:** Preventive care such as:

- ✓ Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- ✓ Digital breast tomosynthesis (3D mammogram).
- ✓ Gynecological examinations.
- ✓ Mammograms.
- ✓ Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- ✓ Pap smears.
- ✓ Physical examinations.
- ✓ Physical examinations required for administrative purposes.

  Benefits Maximum:
  One preventive physical exam (includes separate female gyn exam and pap smear) and one preventive mammogram per benefit period are covered. One preventive physical exam for administrative purposes per benefit period is also covered.
- ✓ Well-child care.

× **Not Covered:**

- × Group lactation consultant services.
- × All treatment related to nicotine dependence, except as described under *Covered*. For prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician, please see your Blue Rx Value Plus prescription drug benefits.

Prosthetic Devices

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

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

× **Not Covered:**

- × Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

Reconstructive Surgery

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

Breast reconstructive surgery includes the following:

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

Repatriation

✓ **Covered:** In the event of death, expenses related to returning the body to the person's place of residence in his or her current home country. Related repatriation expenses may include costs of embalming or cremation, the coffin or urn, and transportation of the body or receptacle. This benefit applies to the employee, spouse, domestic partner, or child covered under this medical benefits plan.

× **Not Covered:** This benefit does not include the transportation expenses of persons accompanying the body.

Self-Help Programs

× **Not Covered:** Self-help and self-cure products or drugs.

Sleep Apnea Treatment

✓ **Covered:** Obstructive sleep apnea diagnosis and treatments.

× **Not Covered:** Treatment for snoring without a diagnosis of obstructive sleep apnea.

Social Adjustment

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

Speech Therapy

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

× **Not Covered:**

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

Surgery

- ✓ **Covered.** This includes the following:
  - ✓ Major endoscopic procedures.
  - ✓ Operative and cutting procedures.
  - ✓ Preoperative and postoperative care.

Telehealth Services

- ✓ **Covered:** You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification or by a practitioner contracting through Doctor on Demand via real-time, interactive audio- visual technology or web-based mobile device or similar electronic-based communication network. Services must be delivered in accordance with applicable law and generally accepted health care practices.

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

- × **Not Covered:** Medical services provided through means other than interactive, real- time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission. You are also not covered for telehealth mental health and chemical dependency services from Doctor on Demand.

Temporomandibular Joint Disorder (TMD)

- ✓ **Covered:** Treatment of TMD.

- × **Not Covered:**
  - × Dental restorations/extractions.
  - × Orthodontic treatment.

Transplants

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

  Transplants are subject to case management.

  The medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.
  Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by your medical benefits.

  To qualify for benefits, the transplant services listed earlier must be from The University of Iowa Hospitals & Clinics or a facility recognized as a Blue Distinction® Center for Transplant. This requirement does not apply to kidney transplants.

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

Transplant Lodging Costs

- × **Not Covered:** Lodging costs are not covered when related to a covered transplant.

Vision Services

- ✓ **Covered:**
  - ✓ Routine vision examinations.
  - ✓ Eyeglasses, but only when prescribed as the result of cataract extraction.
  - ✓ Contact lenses and associated lens fitting, but only when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or corneal disease.

  Benefits Maximum:

  - ✓ One routine vision exam (including refraction) per benefit period is covered.

- × **Not Covered:**
  - × Surgery and services to diagnose or correct a refractive error, including intraocular lenses and laser vision correction surgery (e.g., LASIK surgery).
  - × Eyeglasses, contact lenses, or the examination for prescribing or fitting of eyeglasses or contact lenses, except when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or disease.