



OUTLINE OF COVERAGE

FOR FARM BUREAU HEALTH PLANS
2023 PLAN YEAR

Table of Contents

Choosing a provider	2
About Wellmark Blue HMO SM Network	3
Benefits	4
Limitations	6
Exclusions	7
Plan overview	9
Blue Rx Value SM drug coverage	10
Notification requirements	13
Evaluating the latest technology	14
Privacy practices notices	14
Wellmark Administrators, Inc. protection of Personal Health Information	14
General provisions	15
Health and wellness programs	16
Terms to know	17

This plan is sponsored by the Iowa Farm Bureau Federation, through its wholly owned subsidiary, Farm Bureau Health Benefit Plan, LLC (hereinafter referred to as Farm Bureau Health Plan or FBHP). This Outline of Coverage provides a brief description of the important features of your coverage manual. This is not your coverage manual. The coverage manual will detail the rights and obligations of both you and the Farm Bureau Health Plan and is the controlling document for determination of benefits offered under the plan.

THEREFORE, IT IS IMPORTANT THAT YOU READ YOUR COVERAGE MANUAL CAREFULLY.

If you have questions about this Farm Bureau Health Plan but have not submitted an application, please contact Customer Service at 800-694-4108.

Payments will be made on a calendar month basis through electronic funds transfer only. For example:

Monthly	Payment would be for the first day of the month through the last day of such month through electronic funds transfer (EFT) only.
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In any year in which there is a mid-year change in the amount due, the member will have the following obligation:

Monthly	Monthly payments will continue to be made through electronic funds transfer (EFT) only. For monthly payments, any increase will be deducted from the member's designated account in the first month the increase becomes effective. For each month thereafter, the increased monthly payment will automatically be deducted.
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The amount of your periodic payment may change as provided in the coverage manual and from time to time based on changes in your coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), the number of covered family members, members' ages, changes in tobacco use status, or other factors that require adjustments to the total payment amount. These changes may occur at times other than an annual or other coverage manual renewal.

Your authorization for automatic withdrawals shall include authorization for automatic withdrawal of any changed amount unless you notify your bank no less than three business days before a scheduled withdrawal to stop the payment. You will be responsible for any fee assessed by your bank for stop-payment orders that you make. You can update your bank account information via myWellmark. If you do not have online access to electronically update your bank information, you must complete and submit the Automatic Withdrawal Authorization Form.

Choosing a provider

Farm Bureau Health Plan has chosen to offer you this benefit plan using the Wellmark Blue HMO Network. Providers who participate with this network are called Wellmark Blue HMO Network providers. You can feel secure knowing that through the Wellmark Blue HMO Network, you have access to more than 29,000 providers across the state and access to emergency care nationwide.¹ **Generally, there are no benefits for services received outside of the Wellmark Blue HMO Network, except for emergencies or accidental injuries.**

Benefits for most covered services are available only when received from Wellmark Blue HMO Network providers. Providers who do not participate with this plan are called out-of-network, nonparticipating providers. With the Farm Bureau Health Plan, it is usually to your advantage to visit your primary care provider (personal doctor) for most covered services. If your personal doctor is unable to diagnose or treat your condition, he or she may refer you to another Wellmark Blue HMO Network provider. Generally, benefits are available only when received from Wellmark Blue HMO Network providers. To determine if a provider participates with this medical benefits plan, ask your provider, refer to the Find a Doctor or Hospital tool on IowaFBHealthPlan.com, or call the Customer Service number on your ID card. Our provider directory is also available upon request by calling the Customer Service number on your ID card.

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

Referrals

If you require services from a provider other than your personal doctor, typically a specialist, you will be referred to a provider in the Wellmark Blue HMO Network. If you require services that are not available from a specialist within the Wellmark Blue HMO Network, you will be referred to a provider outside the Wellmark Blue HMO Network who has expertise in diagnosing and treating your condition. Wellmark Administrators, Inc., working on behalf of the Farm Bureau Health Plan, must approve out-of-network referrals before you receive services or the services will not be covered.

Note: Even when your out-of-network referral is approved, you are still responsible for complying with notification requirements.

Primary care providers (PCP)

Primary care providers are a type of provider you go to for your primary care. PCPs include certified nurse midwives, family practitioners, internal medicine practitioners, obstetricians/gynecologists, pediatricians, physicians assistants and advanced registered nurse practitioners.

In the case of preventive care visits and benefits, the following services must be received from a primary care provider for preventive benefits to be covered and cost-share waived:

- Preventive physical exams
- Preventive gynecological examinations
- Well-child examinations

Balance billing

Balance billing is the difference between the billed charge of an out-of-network provider and what the plan will pay for a specific service, procedure, or supply. When you receive emergency care and non-emergency services from a provider who is not part of the Wellmark Blue HMO Network, you are responsible for paying this difference. You are also responsible for paying this difference even with a referral for a non-emergency service if the provider is not part of the Wellmark Blue HMO Network. Non-emergency care is not covered for out-of-network providers. Balance billed amounts do not apply toward your deductible or out-of-pocket maximum and are not used to calculate your coinsurance percentage. To avoid being balance-billed in an emergency or accidental injury situation, select a health care provider who participates in the “traditional” BlueCard® network.

The BlueCard Program is one of the advantages of your coverage. It provides conveniences and benefits outside the Wellmark Blue HMO Network area for emergency care or accidental injury similar to those you would have in the Wellmark Blue HMO Network area when you obtain covered medical services from a network provider. In an emergency situation, seek care at the nearest hospital emergency room. Whenever possible, before receiving services outside the Wellmark Blue HMO Network, you should always ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate BlueCard providers in any state, call 800-810-BLUE, or visit bcbs.com.

¹ Wellmark Blue Cross and Blue Shield network numbers as of January 2021.

About Wellmark Blue HMOSM Network

THE FARM BUREAU HEALTH PLANS outlined here and detailed in the coverage manual are similar to a Health Maintenance Organization (HMO) health plan and are designed to provide specified coverage for hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care. Covered services are subject to deductible, coinsurance, and copayment provisions, or other limitations set forth in the coverage manual.

This coverage is available to you (“single” coverage) or to you and your family (“family” coverage), including your spouse and/or eligible dependent children. You will make payment for coverage directly to Wellmark Administrators, Inc.

Office services received from a Wellmark Blue HMO Network provider

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

Services outside the Wellmark Blue HMO Network

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

- Accidental injuries
- Emergencies
- Referrals to specialists not in-network

BlueCard® Program

Wellmark Administrators, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. Wellmark has relationships with other Blue Cross and/or Blue Shield Plans. These relationships are generally referred to as Inter-Plan Programs. Whenever you obtain services outside the Wellmark Blue HMO Network, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program. These programs ensure that members of any Blue Plan have access to the advantages of participating providers throughout the United States. Participating providers have a contractual arrangement with the Blue Cross or Blue Shield Plan in their home state (“Host Blue”). The Host Blue is responsible

for contracting with and generally handling all interactions with its participating providers.

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

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

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

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

Out-of-network/nonparticipating providers

When you received covered services for accidental injuries or emergencies from out-of-network, nonparticipating providers, all of the following statements are true:

- Out-of-network, nonparticipating providers are not responsible for filing your claims. If you need a claim form or have questions on how to submit a claim, please call the Customer Service phone number located on your ID card.
- Wellmark Administrators, Inc. does not have contracts with out-of-network, nonparticipating providers and they may not agree to accept Wellmark’s payment arrangements. Therefore, you are responsible for any difference between the amount charged and our payment.
- Wellmark Administrators, Inc. makes claims payments to you, not out-of-network, nonparticipating providers.
- You are responsible for notification requirements.

Eligibility for Wellmark Blue HMO Network coverage

All persons seeking coverage with Farm Bureau Health Plan must be residents of Iowa. The applicant must also have and maintain a Farm Bureau membership. If coverage is issued, please note, there are generally no benefits for medical services outside the Wellmark Blue HMO Network except for emergency or accidental injuries.

Benefits

Approved hospital/health care facility services

Farm Bureau Health Plans provide medically necessary services and supplies related to the treatment of an illness or injury as an inpatient in a facility.

Approved health care facilities include ambulatory surgical facilities, hospitals, and nursing facilities. All Farm Bureau Health Plans also consider community mental health centers and facilities for treatment of chemical dependency to be approved health care facilities.

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

Inpatient services

All Farm Bureau Health Plans cover:

- Accidental injury care
- Anesthetics and their administration
- Blood and blood administration
- Chemotherapy services
- Maternity
- Dialysis services
- Drugs and biologicals
- Education services for diabetes
- Emergency care
- General nursing care
- Inhalation therapy
- Intravenous administration
- Medical and surgical supplies such as dressing and casts
- Mental health and chemical dependency treatment, including:
 - Bereavement counseling or services
 - Marriage and family counseling
- Occupational therapy to treat the upper extremities — see *Limitations* section
- Physical therapy — see *Limitations* section
- Speech therapy treatment — see *Limitations* section

Outpatient services

All Farm Bureau Health Plans cover:

- Accidental injury care
- Anesthetics and their administration
- Chemotherapy services
- Dialysis services
- Drugs and biologicals
- Education services for diabetes
- Emergency care
- Inhalation therapy
- Intravenous administration
- Medical and surgical supplies such as dressing and casts
- Mental health and chemical dependency treatment
- 180 day supply for over-the-counter drugs for smoking cessation per calendar year
- Occupational therapy to treat the upper extremities
- Physical therapy
- Rehabilitative speech therapy treatment
- Musculoskeletal services

Approved provider services

The following list describes approved provider services for all Farm Bureau Health Plans:

- Accidental injury services
- Allergy testing and treatment
- Anesthetics and their administration
- Certain dental services
- Chemotherapy
- Routine hearing examinations covered according to the ACA mandate
- Maternity
- Concurrent care
- Dialysis services
- Emergency care
- Medical services-other than surgical or obstetrical
- Musculoskeletal services
- Occupational therapy to treat the upper extremities
- Physical therapy
- Preventive care, including:
 - Implanted and injected contraceptives and contraceptive medical devices — oral contraceptives are covered under your drug coverage manual

- Immunizations
- One routine colorectal cancer screening per member per benefit period.
- One routine gynecological exam per member per benefit period.
- Routine mammograms
- One routine physical examination and related services per member per benefit period.
- One routine prostate cancer screening, for men ages 50-72 years, per member per benefit period.
- Routine pap smears.
- Well-child care including age appropriate pediatric preventive services until the child reaches the age of 7
- Radiation therapy
- Rehabilitative speech therapy treatment
- Surgical services
- Reconstructive surgery
- Fertility services, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only)
- X-ray and laboratory services
- Telehealth services

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

Organ transplant coverage

Coverage is available under all Farm Bureau Health Plans for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, and liver and for certain bone marrow/stem cell transfer transplants.

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

Note: Transplants are subject to case management and are required to be performed at a Blue Distinction® Center.

Other covered services for all plans

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

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

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

- Ambulance services (professional air or ground).
- Home infusion therapy.
- Home medical equipment.
- Short-term home skilled nursing if given by a registered nurse (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, and if coordinated by a Wellmark Administrators, Inc. case manager. Subject to limitations.
- Oxygen and equipment administration.
- Prescription drugs and medicines administered in the vein or muscle covered under the Blue Rx ValueSM managed prescription drug program.
- Prosthetic devices and braces.

Home health services

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

Covered services and supplies include:

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

Hospice services

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

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

Virtual visit¹

Virtual visit, also referred to as Telehealth services, includes covered medical services delivered by an in-network provider via interactive audio-visual technology, web-based mobile device or similar electronic-based communication network or as otherwise required by Iowa law. Virtual visit is the quickest and easiest way to see a doctor or psychologist who can treat the most common medical conditions and prescribe medication, if needed, right from your computer, tablet, or phone from the comfort of home. Doctor on Demand is one provider of these services. When a member uses Doctor on Demand for a virtual visit, they will pay a lower copay.

¹ Wellmark's virtual health care visit benefit is made available through an independent company, Doctor On Demand, Inc., and the telemedicine services are provided by licensed physicians practicing within a group of independently owned professional practices. Doctor On Demand, Inc. does not itself provide any physician, mental health or other healthcare provider services. Doctor On Demand operates subject to state laws. Doctor On Demand offers medical care in 50 states. Doctor On Demand is not intended to replace an annual, in-person visit with a primary care physician.

Limitations

Your Farm Bureau Health Plan coverage is limited as follows:

Breast reconstruction after a mastectomy

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

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

Musculoskeletal treatment

Spinal Manipulation services are limited to a total of 12 self-referred visits per member per benefit period regardless of provider type, unless you get a referral from your personal doctor to continue receiving benefits.

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

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

- For mental health:
 - Treatment provided in an office visit, or outpatient setting;
 - Treatment provided in an intensive outpatient setting;
 - Treatment provided in an outpatient partial hospitalization setting;
 - Individual, group, or family therapy provided in a clinically managed low intensity residential treatment setting, also known as supervised living;
 - Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
 - Psychiatric observation;
 - Care provided in a psychiatric residential crisis program;

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

Occupational, physical and speech therapy

Farm Bureau Health Plans provide coverage for occupational, speech and physical therapy subject to the benefit terms outlined in your coverage manual:

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

- Speech therapy does not cover:
 - Speech therapy services not provided by a licensed or certified speech pathologist.
 - Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.
- Physical therapy does not cover:
 - Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
 - Physical therapy performed for maintenance.
- Coverage for occupational, physical, and speech therapy is limited to:
 - 35 visits combined per benefit year for the outpatient or office therapy services related to occupational therapy, physical therapy, and speech therapy.

Hospice respite care

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

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

Organ Transplants

Coverage is limited to Blue Distinction Centers and subject to prior approval and case management.

Home skilled nursing

Coverage for home skilled nursing is limited to:

- 30-day inpatient limit
- 60-day in-home limit

Exclusions

The following services are excluded or are not considered medically necessary by Farm Bureau Health Plans and will not be covered under your Farm Bureau Health Plan:

Counseling and educational Services

All Farm Bureau Health Benefits Plans exclude coverage for:

- Services of volunteers or clergy
- Genetic counseling
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, the treatment of obesity, including exercise modalities, nutritional instruction for the control of gastrointestinal conditions, reading programs for dyslexia, or Applied Behavior Analysis services, for any medical, mental health, or substance abuse condition.

Mental health treatment

All Farm Bureau Health Benefits Plans exclude coverage for:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Conditions that are not pervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric or chemical dependency treatment programs.

Fertility and infertility

All Farm Bureau Health Plans exclude coverage for:

- Elective abortion.
- Infertility diagnosis and treatment.
- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs) when performed in

connection with fertility or infertility procedures or for any other reason or service; freezing of sperm, oocytes, or embryos; surrogate parent services.

- Artificial insemination, in vitro fertilization, or any related fertility or infertility treatment or transfer procedure. If you have any of these procedures done, benefits for all types of fertility or infertility treatment (including drug induced stimulation of ovulation) will end beginning on the day you receive the non-covered service.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Miscellaneous

All Farm Bureau Health Plans exclude coverage for:

- Access to clinical trials
- Anesthesia, local or topical billed separately from a related surgical or medical procedure
- Orthotics
- Biofeedback
- Complications of a non-covered service, supply, device, or drug
- Cosmetic surgery
- Dental services except as specified and limited in the coverage manual
- Elastic stockings and bandages
- Extended home skilled nursing, which is treatment provided in the home by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) who is associated with JCAHO or a Medicare-certified agency. Additionally, this treatment is ordered by a physician and consists of four or more hours per day of continuous nursing care that requires the technical proficiency and knowledge of an R.N. or L.P.N.
- Hearing aids
- Genetic testing and related counseling
- Investigational treatment
- Maxillary and mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease

- Motor vehicle special equipments
- Non-medical services
- Personal convenience items
- Rehabilitative speech therapy treatment not provided by a licensed or certified speech pathologist. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering.
- Routine vision care
- Services furnished to you prior to the date your coverage manual begins
- Travel or lodging costs
- Treatment of temporomandibular joint syndrome including related dental extractions, dental restorations, or orthodontic treatments
- Wigs or hairpieces

Organ transplants

All Farm Bureau Health Plans exclude coverage for:

- Expenses related to purchase of any organ
- Services or supplies related to mechanical or non-human organs associated with transplants
- Transplant services or supplies other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/ stem cell transfers
- Expenses of transporting living donor or recipient
- Expenses of transporting the recipient when the transplant organ for the recipient is not available for transplant.

Provider types

These providers are excluded on all Farm Bureau Health Plans:

- Provider, if an immediate family member

Covered by other programs or laws

All Farm Bureau Health Plans exclude coverage for:

- Illness or injury sustained while on active military status
- Services or supplies for which we learn or are notified by you, your provider, or our third party contractor that such services or supplies are related to a work related illness or injury.
- Services provided under a direct primary care agreement
- Services or supplies when someone else has the legal obligation to pay for services, has an agreement to not submit claims for services or, without this health plan, there would not be a charge.

Therapy, self-motivation, and other programs

All Farm Bureau Health Plans exclude coverage for:

- Acupuncture
- Cosmetic services, supplies or drugs if provided primarily to improve physical appearance. A service, supply or drug that results in an incidental improvement

in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

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

Additional exclusions

- Amino acid-based elemental infant formula, up to age 2
- Bariatric Surgery
- Breast Reduction
- Children's early intervention services, up to 36 months
- Coverage for Autism Spectrum Disorders including behavior analysis
- Family Planning
- Gender identity and reassignment
- Lamaze
- Metabolic formula & low protein food for inborn errors of metabolism
- Routine foot care
- Routine vision/eye exams
- Periodic physicals or health examinations, screening or immunization procedures that are performed solely for school, sport, employment, insurance, licensing, or travel
- Symptomatic Varicose Vein Surgery

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

Plan overview

PLAN NAME	IOWA CHOICE 3500	IOWA CHOICE 6000	IOWA CHOICE 6650 HIGH DEDUCTIBLE HEALTH PLAN
Farm Bureau membership required?	Yes	Yes	Yes
Preventive care	FREE ¹	FREE ¹	FREE ¹
Annual benefit: Deductible ²	Single: \$3,500 Family ³ : \$7,000	Single: \$6,000 Family ³ : \$12,000	Single: \$6,650 Family ³ : \$13,300
Annual benefit: Out-of-pocket maximum	Single: \$7,500 Family ³ : \$15,000	Single: \$10,000 Family ³ : \$20,000	Single: \$6,650 Family ³ : \$13,300
Lifetime benefit maximum	\$3,000,000	\$3,000,000	\$3,000,000
Coinsurance	20%	30%	0%
Office services: Out-of-network	Not covered except for emergency and accidental injury only	Not covered except for emergency and accidental injury only	Not covered except for emergency and accidental injury only
Primary Care Provider ⁴ (PCP) office visit walk-in clinic, independent lab services, Facility lab/X-ray	\$35 copay ⁵	\$75 copay ⁵	Deductible applies
Specialist ⁶ (Non-PCP) office visit physical therapy, occupational therapy, or speech pathology (outpatient), X-rays (outside of office visit)	\$75 copay ⁵	\$150 copay ⁵	Deductible applies
Emergency room (includes physician, facility, labs and x-rays; copays waived if admitted as inpatient)	\$400 copay ⁵	\$600 copay ⁵	Deductible applies
All other services (i.e. ultrasounds, inpatient, ambulance, skilled nursing facility, outpatient physician and facility services, diagnostic imaging/studies and radiation therapy, nuclear medicine, diagnostic mammograms, diagnostic testing, durable medical equipment)	Deductible applies	Deductible applies	Deductible applies
Virtual visits	Doctors on Demand: \$25 copay ⁵ PCP: \$35 copay ⁵ Non-PCP: \$75 copay ⁵	Doctors on Demand: \$25 copay ⁵ PCP: \$75 copay ⁵ Non-PCP: \$150 copay ⁵	Deductible applies
Rx formulary	Blue Rx Value	Blue Rx Value	Blue Rx Value
Prescription drug benefits	Generics (Tier 1): \$15 copay ⁵ Preferred brand (Tier 2): \$40 copay ⁵ Preferred specialty: \$300 copay ⁵	Generics (Tier 1): \$15 copay ⁵ Preferred brand (Tier 2): \$40 copay ⁵ Preferred specialty: \$300 copay ⁵	Medical deductible applies After deductible, plan pays 100% of covered drugs.

¹ Preventive care services must be received from a Primary Care Provider in the Wellmark Blue HMO Network.

² Member has benefits after single deductible is met and then entire family has benefits after family deductible is met when the deductible is applicable.

³ The family deductible or out-of-pocket maximum can be met through any combination of family members. No one member will be required to meet more than the single deductible or out-of-pocket maximum amount to receive benefits for covered services during a benefit period.

⁴ The primary care office copay applies to certified nurse midwives, family practitioners, general practitioners, obstetricians/gynecologists, pediatricians, physicians assistants and advanced registered nurse practitioners. This lower office copay applies to in-network chiropractors, physical therapists, occupational therapists, speech pathologists, and in some cases, mental health or chemical dependency visits. The copay applies per practitioner, per date of service.

⁵ The member is responsible for all copay amounts after the out-of-pocket maximum is met.

⁶ The specialist office copay applies to non-primary care physicians or all other in-network practitioners not listed as a primary care provider. Members will also pay this specialist copay for physical therapy, occupational therapy, or speech pathology services performed in an outpatient setting. This non-PCP office copay also applies to X-rays done outside of an office visit. The copay applies per practitioner, per date of service.

Blue Rx ValueSM drug coverage

Most prescription drugs are covered under Blue Rx Value, your managed drug program. Farm Bureau Health Plan members must fill their prescriptions through any of the more than 65,000 participating pharmacies nationwide¹ — whether in or out of state — and will have their claims filed electronically by the pharmacy. Specialty drugs must be purchased through the specialty pharmacy program. Blue Rx Value retail pharmacies as well as specialty pharmacies have point-of-sale computer access to current information to screen for duplicate therapies or interactions with drugs dispensed by other Blue Rx Value Plus Network pharmacies.

Blue Rx ValueSM Prescription Drug Card Plan

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

The Blue Rx Value Drug List

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

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

To determine if a drug is covered, you must consult the Blue Rx Value Drug List. You are covered for drugs listed on the Blue Rx Value List. **If a drug is not on the Drug List, it is not covered.** If you need help determining if a particular drug is on the Blue Rx Value Drug List, ask your physician or pharmacist, visit Wellmark.com, or call the Customer Service number on your ID card and request a copy of the Drug List.

New drugs will not be added to the Drug List until they have been evaluated by Wellmark Administrators, Inc. Wellmark will periodically update the list to reflect these

evaluations and to reflect the changing drug market in general. Although only drugs listed on the Drug List are covered, Wellmark Blue HMO Network providers are not limited to prescribing only the drugs on the list. Wellmark Blue HMO Network providers may prescribe any medication, but only medications on the Drug List are covered. A medication on the Drug List will not be covered if the drug is specifically excluded under your prescription drug plan, or other limitations apply. The Blue Rx Value Drug List is subject to change.

Understanding tiers and what you pay

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

Blue Rx Value

- **Tier 1** — Most generic drugs and some brand-name drugs that have no generic equivalent.
- **Tier 2** — Drugs appear on this tier because they either have no generic equivalent or are considered less cost-effective than Tier 1 drugs.
- **Preferred Specialty** — Drugs have proven to be safe, effective, and favorably priced compared to non-preferred alternatives that treat the same condition. Drugs may also be classified as preferred because no alternative drug exists.

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

Guidelines for drug coverage

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

- Listed on the Drug List.
- Can be legally obtained in the United States only with a written prescription.
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962.
- Prescribed by a practitioner prescribing within the scope of his or her license.
- Dispensed by a recognized, licensed, participating retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program or through the mail order drug program.
- Medically necessary for your condition.
- Reviewed, evaluated, and recommended for addition to the Drug List by Wellmark Administrators, Inc.

Limits on prescription drug coverage

We may exclude, discontinue, or limit coverage for any drug by removing it from the Drug List or by moving a drug to a different tier on the Drug List for any of the following reasons:

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

¹ CVS Health, 2018

Drugs that are not covered

Drugs not covered include but are not limited to:

- Drugs not listed on the Blue Rx Value Drug List.
- Drugs purchased from nonparticipating pharmacies.
- Specialty drugs purchased outside the specialty pharmacy program.
- Drugs in excess of a quantity limitation.
- Drugs that are not FDA approved.
- Experimental or investigational drugs.
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain.
- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug.
- Drugs determined to be abused or otherwise misused by you.
- Drugs that are lost, damaged, stolen, or used inappropriately.
- Contraceptive medical devices, such as intrauterine devices and diaphragms. These are covered under your medical benefits.
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.
- Cosmetic drugs.
- Irrigation solutions and supplies.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Weight reduction drugs.
- The difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved “A”-rated medically appropriate generic equivalent.

Refills

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

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the

medication has been taken according to the instructions given by your Wellmark Blue HMO Network provider.

- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your Wellmark Blue HMO Network provider.
- The refill is not limited by state law.

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

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

Quantity limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. Federal regulations limit the quantity that may be dispensed for certain medications.

If your prescription is so regulated, it may not be available in the amount prescribed by your Wellmark Blue HMO Network provider. In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered. For a list of drugs with quantity limits, check with your pharmacist or Wellmark Blue HMO Network provider, consult the Blue Rx Value Drug List at Wellmark.com, or call the Customer Service number on your ID card.

Prior authorization of drugs

- **Purpose** — Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary. In some cases prior authorization may also allow a drug that is

normally excluded to be covered if it is part of a specific treatment plan and medically necessary.

- **Applies to** — Prior authorization is required for a number of particular drugs. Visit Wellmark.com or check with your pharmacist or Wellmark Blue HMO Network provider to determine whether prior authorization applies to a drug that has been prescribed for you.
- **Person responsible** — You are responsible for the prior authorization.
- **Process** — Ask your Wellmark Blue HMO Network provider to call Wellmark with the necessary information. If your Wellmark Blue HMO Network provider has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription. We will respond to a prior authorization request within:
 - 72 hours in a medically urgent situation.
 - 15 days in a non-medically urgent situation. Calls received after 4 p.m. are considered the next business day.
- **Importance** — If you purchase a drug that requires prior authorization but do not request prior authorization, you are responsible for paying the entire amount charged.

Prescription maximums

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

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

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

90 day mail order maintenance
30 day specialty

Mail order drug program

You must purchase mail order drugs through the mail order drug program. You are not covered for mail order drugs purchased outside the mail order drug program. You must register as a mail service user in order to fill your prescriptions through the mail order drug program. For information on how to register call the Customer Service number on your ID card. Mail order pharmacy providers outside our mail order program are considered nonparticipating pharmacies. You are not covered for drugs purchased from nonparticipating mail order pharmacies.

Specialty drugs

Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They are not available through the mail order drug program. Specialty drugs may be covered under your Blue Rx Value prescription drug benefits. To determine whether a particular specialty drug is covered under your Blue Rx Value prescription drug benefits, consult the Blue Rx Value Drug List at Wellmark.com, or call the Customer Service number on your ID card.

Specialty pharmacy program

Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. You must purchase specialty drugs through the specialty pharmacy program. You must register as a specialty pharmacy program user in order to fill your prescriptions through the specialty pharmacy program. For information on how to register, call the Customer Service number on your ID card. You are not covered for specialty drugs

purchased outside the specialty pharmacy program. A specialty pharmacy program administers the distribution of specialty drugs to the home and to physicians' offices. If a specialty drug is not on the Drug List, it is not covered.

Preventive items and services

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

Drug company rebates

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

Prescription purchases outside the United States

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

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same name

and dosage form as the FDA-approved drug's active ingredient.

- The prescription drug would require a written prescription by a licensed Wellmark Blue HMO Network provider if prescribed in the U.S.

Notification requirements

The following are notification requirements you or your Wellmark Blue HMO Network provider should follow to receive the maximum benefits available under your Farm Bureau Health Plan.

Precertification

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

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

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

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

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

Concurrent review

Concurrent review is a utilization review conducted during a member's facility stay or course of treatment at home or in a facility setting to determine whether the place or level of service is medically necessary. This care coordination program occurs without any notification required from you.

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

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

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

Before receiving laboratory services, home/durable medical equipment, or prosthetic devices, ask your provider to utilize a provider that has a contractual arrangement with the Blue Plan where you received services, purchased/rented equipment, or shipped equipment. If the provider does not have a contractual relationship with the Blue Plan, that provider will be considered a nonparticipating provider and you will be responsible for the entire amount charged.

Prior approval

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

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

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

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

Change of residence

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

Notification

Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination.

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

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

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

Evaluating the latest technology

Wellmark Administrators, Inc. regularly reviews the latest procedures, drugs, devices, and methods that will improve medical outcomes.

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

Privacy practices notices

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

- How your medical information may be used and disclosed.
- How you can get access to information regarding the use of your medical information.
- How you can authorize Wellmark to release your medical information upon approval.

Or call the Customer Service number located on the back of your ID card for questions.

For Farm Bureau Health Plan's HIPPA Notice of Privacy Practices, please visit www.iowafbhealthplan.com.

Wellmark's internal protection of Personal Health Information

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

- a. Disseminated Notice of Privacy Practices to covered members and posted it on the Wellmark website at Wellmark.com.
- b. Disseminated a Notice of Privacy Practices and other information practitioners and facilities need to know about Wellmark's privacy practices in the provider newsletter, Blue InkSM, and on the Wellmark website.
- c. Established a Privacy Office as a primary point of contact concerning questions or issues regarding privacy matters, including toll-free phone access and email address, and published the contact information in the Notice of Privacy Practices on the Wellmark website.
- d. Established internal policies and procedures for compliance with the Privacy Rule, and disseminated the information to employees through corporate-wide privacy training, and department-specific training for Customer Service and other areas.

- e. As a condition of employment, all members of Wellmark's workforce are required to sign a Confidentiality and Nondisclosure Agreement.
- f. In daily interaction with members and providers, Wellmark provider and Customer Service representatives inform providers and members of our procedures to verify identity and authority of callers to discuss protected health information.
- g. Limited physical and information system access to medical information, only to people who need it to do their jobs.
- h. Strict security regarding access to facility, personal computers, and medical information.

General provisions

Eligibility: You are eligible to apply for a Farm Bureau Benefit Plan if:

- You are an Iowa Farm Bureau Federation member
- You are an Iowa resident
- You pass Farm Bureau Health Plan's underwriting criteria.
- You are 18 years or older as the primary applicant.
- You are not eligible for Medicare, Medicaid, or group coverage.

Payment Information

- Coverage is automatically renewed by advance payment.
- After the first payment is made you will be granted a grace period of 31 days for each subsequent payment.
- We may terminate your coverage manual if:
(1) you fail to make a payment when due;
(2) there is fraudulent use of your coverage manual; (3) Farm Bureau Health Plan terminates or discontinues your plan; (4) you change your residence from Iowa. You must notify us prior to relocating outside of Iowa, as you will have no benefits for services except for emergencies or accidental injuries; or (5) you fail to maintain your Iowa Farm Bureau membership.
- We may rescind your coverage manual if it is determined you failed to disclose an existing health condition at the time of application.

Subrogation

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

Coordination of benefits

This plan will not coordinate benefits with other coverage¹. You are responsible for notifying Farm Bureau Health Plan of any other coverage, or cancelling any duplicate coverage. This plan will always process claims as if it is the primary coverage.

¹ Other coverage includes Group Health coverage, individual health insurance, or creditable coverage (not including HIPIOWA, Medicaid, or hawk-i)

Health and wellness programs

Helping you maintain or improve your health is important. In support of your health care coverage, Wellmark provides programs and services with your health and wellness needs in mind.

Blue365®

When you become covered under a Farm Bureau Health plan, you become a member of The Blues®, and you have access to discounts and services through Blue365, a program designed by the Blue Cross and Blue Shield Association.

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

- **Health and wellness** — referrals and savings on elective procedures, such as laser vision correction surgery, discounts on weight-loss programs like Jenny Craig®, and fitness clubs like SNAP Fitness™.
- **Family care** — support and information for parents or dependents in need of caregiver services.
- **Financial well-being** — access to help planning for your future.
- **Travel** — discounts on healthy vacations, lodging, destination-specific travel tips, and assistance with passport issues and inquires.

Pregnancy Care program

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

Complex Case Management program

Wellmark Administrators' Complex Case Management program is designed to provide you with long-term health care needs resulting from extreme illness or injury. You, your Wellmark Blue HMO Network provider, and the hospital work with our case managers to identify and arrange treatment plans in an effort to meet your special needs and to assist in preserving your health insurance benefits.

Wellmark Administrators, Inc. may from time to time make available to you certain health support services. Wellmark Administrators may offer financial and other incentives to you to use such services. As part of the provision of such services, Wellmark Administrators may: (1) use your personal health information (including but not limited to: substance abuse, mental health, and AIDS/HIV information), and (2) disclose such information to your health care providers and Wellmark vendors, for purposes of providing such services to you. When using such information, Wellmark Administrators will do so according to the terms of Wellmark's Privacy Practices Notices, which can be accessed at Wellmark.com/Inform.

Terms to know

Deductible

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

Family deductible

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

Copayments

Specific dollar amounts you pay at the time you receive covered services. Copayments will continue after the out-of-pocket maximum is met.

Coinsurance

The shared cost of a covered health care service, calculated as a percent of allowed amount for the service.

Out-of-pocket maximum (OPM)

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

Wellmark Blue HMO Network savings

The amount saved due to contracts Wellmark Administrators, Inc. has with providers.

Payment arrangement

Wellmark Administrators, Inc. has contracting relationships with network providers and uses different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

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

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

charged and the maximum allowable fee for services from a nonparticipating provider.

- **Amount paid by health plan** — Reflects Wellmark's payment responsibility to a provider or to you. Wellmark determines this amount by subtracting the following amounts (if applicable) from the amount charged:
 - Deductible
 - Coinsurance
 - Copayment
 - Amounts representing any general exclusions and conditions
 - Network savings

Payment method for services

Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific claims and are not considered when determining any amounts you may owe. Wellmark reserves the right to change the methodology used to calculate payment arrangements based on industry practice or business need. Network providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

This is a general description of plans. It is not a statement of contract. Actual coverage is contained in the terms and conditions specified in the coverage manual itself and enrollment rules in force when the coverage manual becomes effective. In the event of any discrepancy between the summary outline of coverage and the coverage manual, the terms of the coverage manual control.

This coverage is not required to comply with certain federal or state market requirements for health insurance, principally those contained in the Affordable Care Act and this coverage is not considered "minimum essential coverage" under the ACA. Be sure to check your certificate carefully to make sure you are aware of eligibility requirements, exclusions, or limitations for coverage. Your certificate may also have a lifetime or annual dollar limit on health benefits. If this coverage expires, or you lose eligibility, you may have to wait for an Open Enrollment Period to get other health coverage.

If you have questions or need additional information:

Please call your agent or Wellmark Administrators, Inc.

Wellmark Administrators, Inc.
P.O. Box 9232
Des Moines, IA 50306-9232
Wellmark.com
800-694-4108

Wellmark Administrators, Inc.

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