

O u t l i n e o f C o v e r a g e



BlueSelect[®]

H e a l t h P l a n s f o r I n d i v i d u a l s a n d F a m i l i e s

www.wellmark.com

You should read your policy carefully. This outline of Blue Select coverage provides a brief description of the important features of your policy. This is not your policy. Only the actual benefit provisions in your policy will determine your benefits. The policy itself sets forth in detail the rights and obligations of both you and Wellmark Blue Cross and Blue Shield of South Dakota.

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

BlueSelect

The Blue Select plans outlined here and detailed in the policies are designed to provide you coverage for hospital, medical, and surgical expenses incurred as a result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care. Covered services are subject to the copayment, deductible and coinsurance provisions, or other limitations set forth in the policy.

This coverage is available to you (“single” coverage), to you and your spouse or to your unmarried dependent child (“two-person” coverage), or to you and your family (“family” coverage, including your spouse and/or unmarried dependent children). You will pay the premium for coverage directly to Wellmark Blue Cross and Blue Shield of South Dakota. This type of program is referred to as “individual coverage.”

terms to know

Deductible

A deductible is the fixed dollar amount you pay for covered services before benefits are available.

The family deductible 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.

Deductible and Coinsurance Waived for Office Services

You are not required to pay any deductible or coinsurance amount for covered office services performed in a Blue Select practitioner’s office. You are only responsible for the applicable copayment, depending on which Blue Select plan you choose.

(Note: Some laboratory testing performed in the office is sent outside of the office for processing. When this happens, deductible and coinsurance may apply to the laboratory testing if it is sent to a non-Select provider for processing. If lab testing is sent to a Select or BlueCard PPO practitioner for processing, deductible and coinsurance apply.)

Out-of-Pocket Maximum

The maximum amount you pay for covered services in a benefit period is called the out-of-pocket maximum. Your out-of-pocket maximum equals the deductible and

coinsurance amounts you pay during a benefit period. You will pay more than this amount if you receive services from a non-participating provider who does not accept our payment arrangement amount, or if you receive services that are subject to limitations.

Lifetime Benefit Maximum

In a covered person’s lifetime, total benefits accumulated under this policy and any other individual policy issued by Wellmark Blue Cross and Blue Shield of South Dakota are limited to \$2,000,000.

Provider Payment Arrangements

We use various methods to determine payment arrangements, including negotiated fees, based upon our contracting relationships with providers. These payment arrangements usually result in savings and can affect how your coinsurance is calculated.

Billed Charge—The amount a provider bills for any services whether or not they are covered under your policy.

Covered Charge—The amount a provider bills for services covered under your policy.

Maximum Allowable Fee—The amount we establish, using various methodologies, for covered services.



Blue Select Provider Network

Blue Select is a preferred provider organization, a unique network of contracted providers that offers financial incentives to seek care from those providers. Some key features of Blue Select:

- You may see any provider you choose – in South Dakota or outside the state, but you have financial incentives to see Blue Select or BlueCard PPO providers.
- The coinsurance you pay is less for services from Blue Select providers.
- The deductible and coinsurance are waived for office services from Blue Select providers; a copayment applies instead.
- Blue Select providers accept our settlement as payment in full for covered services.
- Blue Select providers take care of necessary notification requirements.



The Blue Select plans featured in this outline of coverage have varying benefits. You may select one of the plans below:

	\$500	\$1,000	\$1,500	\$2,500	\$5,000
Deductible					
Single	\$ 500	\$1,000	\$1,500	\$2,500	\$ 5,000
Two-Person	\$1,000	\$2,000	\$3,000	\$5,000	\$10,000
Family	\$1,500	\$3,000	\$4,500	\$7,500	\$15,000
Coinsurance - You Pay					
Select Providers	10%	15%	20%	20%	20%
Non-Select Providers	20%	25%	40%	40%	40%
Out-Of-Pocket Maximum					
Single	\$1,500	\$2,000	\$2,500	\$3,500	\$ 6,000
Two-Person	\$3,000	\$4,000	\$5,000	\$7,000	\$12,000
Family	\$4,500	\$6,000	\$7,500	\$10,500	\$18,000
Office Copayment - You Pay	\$10	\$15	\$20	\$20	\$20
Preventive	Yes	No	Yes	Yes	Yes
Maternity	Yes	Yes	Yes	*No	*No
Mental Health Treatment	Yes	Yes	Yes	Yes	Yes
Alcohol/Chemical Dependency Treatment	**Yes	**Yes	**Yes	Inpatient Only Covered	
Prescription Drugs - Covered on all Blue Select Plans subject to the same deductible as any other covered service. The coinsurance is that for non-Select providers.					

*Complications only are covered by these plans.

**Covered subject to limitations shown on page 4.

benefits

Approved Hospital/Health Care Facility Services

The Blue Select program provides coverage for medically necessary services and supplies related to the treatment of an illness or injury for an unlimited number of days when care is received as an inpatient in a facility. Approved health care facilities include ambulatory surgical facilities, community mental health centers, facilities for treatment of chemical dependency, hospitals, and nursing facilities.

Facility Services

The following list describes approved facility services that are covered on an in- and outpatient basis, unless specifically stated otherwise.

- Accidental injury services
- Anesthetics and their administration
- Blood administration
- Chemotherapy services
- Corneal grafts
- Dietary services—*but only as an inpatient or when prescribed by a physician for treatment of Phenylketonuria (PKU)*

- Dressings and casts
- Drugs and biologicals
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical emergency care
- Medical and surgical supplies
- Mental health conditions
- Occupational therapy—*limited to treatment of the upper extremities*
- Physical therapy
- Rooms—including general nursing care and meals as an inpatient, or when prescribed by a physician for the treatment of Phenylketonuria (PKU)
- Special care units including burn care units, cardiac care units, delivery rooms, intensive care units, isolation rooms, operating rooms, and recovery rooms
- Speech therapy—*limited to restoration of loss due to illness or injury*

Approved Practitioner Services

Some approved practitioners include:

certified registered nurse anesthetists, chiropractors, dentists, doctors of osteopathy, licensed independent social workers, medical doctors, nurse midwives, nurse practitioners, occupational therapists, optometrists, oral surgeons, physical therapists, physician assistants, podiatrists, psychologists, and qualified mental health professionals. The following list describes approved practitioner services:

- Accidental injury services
- Anesthetics and their administration
- Assisting surgeon services
- Chemotherapy services
- Concurrent care
- Consultation services
- Corneal grafts
- Dental treatment for accidental injury
- Diagnostic screening for prostate cancer including:
 - 1) An annual medically recognized diagnostic examination, including a digital rectal examination and a prostate-specific antigen test, for:
 - a. Asymptomatic men age 50 and over; and
 - b. Men age 45 and over at high risk for prostate cancer; and
 - 2) Males of any age who have a prior history of prostate cancer, medically indicated diagnostic testing at intervals recommended by a physician, including the digital rectal exam, prostate-specific antigen test, and bone scan.
- Hemodialysis services
- Maternity services including pre- and postnatal care, and delivery (only covered under Plans \$500, \$1,000, and \$1,500). Complications of pregnancy are covered under all plans
- Medical emergency care
- Medical services (other than surgical or obstetrical) provided by your practitioner while you are an inpatient or an outpatient, including home and office calls
- Mental health conditions
- Occupational therapy for upper extremities
- Physical therapy
- Preventive care, including well child care to age 2, immunizations, annual physical, and annual gynecological exam. (Covered on all plans except Plan \$1,000)
- Radiation therapy
- Routine medical care of a newborn during the mother's hospitalization if added to the contract within 31 days of birth
- Routine mammography x-ray: for women 35-39 years of age, one baseline mammogram; 40-49 years of age, one mammogram every two years; 50 years of age and older, one mammogram every year
- Surgical services
- Tubal ligation or vasectomy (only covered under Plans \$500, \$1,000 and 1,500)
- X-ray and laboratory services

Other Covered Services

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

- Ambulance
- Certified diabetes education program (including insulin, insulin supplies, insulin syringes, and glucose strips)
- Home infusion therapy
- Home medical equipment
- Oxygen and equipment needed to administer oxygen
- Prescription drugs and medicines
- Private-duty nursing
- Prosthetic appliances

Home Health Services

Coverage includes care provided by a home health agency. Services must be prescribed by a physician when you are home bound 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
- Inhalation therapy
- Medical equipment and supplies
- Medical social services
- Occupational therapy (upper extremities only), physical therapy, and speech therapy
- Oxygen and equipment
- Parenteral and enteral nutrition
- Prescription drugs and medicines
- Prosthetic appliances and braces
- Skilled nursing visits

Hospice Services

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice care includes the same services as described under home health, as well as respite care.

Respite care offers rest and relief help for the family caring for a terminally ill patient. Benefits for respite care are limited to a lifetime maximum of 15 days for inpatient and 15 days for outpatient care. Benefits must be used in increments of five days or less.

Supplemental Accident Option

This optional benefit may be added to your Blue Select coverage. Supplemental accident coverage includes up to \$500 of expenses for professional medical treatment or attention (except dental treatment) received within 90 days of the date of the accidental injury. This benefit is not subject to any deductible or coinsurance provisions of the base policy. For expenses in excess of \$500, deductible and coinsurance provisions will apply.

limitations

Your Blue Select coverage is limited as follows:



Become familiar with your policy's limitations and exclusions.

Pre-Existing Condition

Waiting Period

A pre-existing condition waiting period of 11 consecutive months applies if the covered person requiring services or supplies has a pre-existing condition and:

- neither you nor any covered person had creditable coverage within 63 days of your application date for the Blue Select Plans; or
- the covered person's creditable coverage was not in effect for a sufficient amount of time to satisfy the 11 consecutive month waiting period for pre-existing conditions under this coverage. In this case, the 11-month waiting period for pre-existing conditions applicable to each family member under this coverage will be credited for the amount of time each family member was covered under the creditable previous coverage.

Chemical Dependency Treatment

Coverage for chemical dependency treatment is limited to:

- **30 days** for the inpatient treatment of alcoholism in each six month period; and **90 days** lifetime.
- **30 days** per benefit period for the inpatient treatment of chemical dependency, excluding treatment for alcoholism (only covered under Plans \$500, \$1,000 and \$1,500).
- **\$10,000** lifetime for the *outpatient* treatment of chemical dependency including treatment of alcoholism (only covered under Plans \$500, \$1,000 and \$1,500).

Cosmetic Surgery

Benefits for cosmetic surgery are limited to corrective surgery that has the primary purpose of restoring function after an illness or accidental injury, or is the result of a birth or physical defect.

Breast Reconstruction after 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.

Organ Transplants

Coverage is available under these policies for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and, in limited instances, small bowel. Coverage is limited for certain autologous and allogeneic bone marrow/stem cell transfer transplants as described in the policy. Other limitations for transplants include:

- Services for transportation in an ambulance to a transplant center are limited to a \$10,000 maximum per transplant.
- You should follow written prior approval requirements for all transplants, except kidney.

exclusions

The following services are excluded or are not considered medically necessary by Wellmark Blue Cross and Blue Shield of South Dakota and will not be covered.

Mental Health and Chemical Dependency Treatment

- Bereavement counseling or services
- Certain development and learning disorders
- Certain disorders of early childhood, such as academic underachievement disorder
- Communication disorders, such as stuttering and stammering
- Impulse control disorders, such as pathological gambling
- Marriage and family counseling
- Nicotine dependence
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders, including sex change surgery

Fertility and Infertility

- Contraceptives
- Services provided for the collection of donor semen, oocytes, or the services of a surrogate parent
- Infertility treatment
- Sterilization reversal
- Subcutaneous implants
- Services provided for the treatment of impotence unless it is the result of a physical illness or injury

Miscellaneous

- Anesthesia, local or topical
- Arch supports
- Blood
- Complications of a non-covered procedure
- Dental services except as specified and limited in the policy
- Elastic stockings and bandages
- Genetic counseling

- Hearing aids and exams
- Investigational treatment
- Maxillary and mandibular implants
- Motor vehicles
- Nonmedical services
- Personal convenience items
- Services furnished to you prior to the effective date of the policy
- Travel or lodging costs
- Vision care
- Wigs

Provider Types

- Certified registered nurses (other than an anesthetist)
- Provider is an immediate family member
- Social workers, except as described in your benefits policy

Preventive and Routine Care

- Routine foot care
- Immunizations (Plan \$1,000)
- Routine examinations (Plan \$1,000)
- Well-child care (Plan \$1,000)

Covered by Other Programs or Laws

- Benefits under this policy will not duplicate benefits provided by Medicare
- Services or supplies when someone else has the legal obligation to pay for your care
- Military-related illness or injury
- Services or supplies that are paid under Workers' Compensation

Therapy, Self-Motivation, and Other Programs

- Acupuncture

- Services and supplies as an inpatient provided primarily for diagnostic evaluation, physical therapy, or occupational therapy
- Cosmetic services and supplies
- Custodial or sanitarium care or rest cures
- Educational or recreational therapy
- Massage therapy
- Occupational therapy supplies
- Self-help or self-cure programs
- Weight reduction programs

Transplants

- Expenses for the purchase of any organ
- Mechanical or non-human organs
- 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
- Transportation of a living organ donor

Additional Exclusions That Apply Only to Plans \$2,500 & \$5,000

- Abortion
- Maternity services
- Sterilization
- Treatment of temporomandibular joint disorder (TMD)
- Chemical dependency, except for inpatient treatment of alcoholism

notification requirements

The following are notification requirements you or your Blue Select provider must follow to receive the maximum benefits available under your policy.

We work with you and your provider to make sure your benefits are used in the most cost-effective settings.

Inpatient Admission Notification

Within one business day after you are admitted to a hospital, Wellmark Blue Cross and Blue Shield of South Dakota must be notified. If you receive covered services from a non-Blue Select provider, you are responsible for notifying Wellmark Blue Cross and Blue Shield of South Dakota of an admission. If you or your provider do not notify us as required, your benefits will be denied if the services provided are not medically necessary or are not covered by your policy. If you or your provider do not notify us as required and services provided are medically necessary and covered by your policy, you may pay as much as 50 percent of the cost of your care yourself up to a maximum of \$1,000 per admission—and that is in addition to any applicable deductible or coinsurance amounts that are applied to the remaining balance.

Precertification

Precertification is a process whereby you or your provider notify Wellmark Blue Cross and Blue Shield of South Dakota before a planned admission to an out-of-network or out-of-state facility, a nursing facility or acute rehabilitation facility. Precertification is also required before receiving home health, hospice, home infusion therapy, private duty nursing, or mental health and chemical dependency services. During precertification, Wellmark Blue Cross and Blue Shield of South Dakota checks benefit eligibility and determines whether medical necessity standards have been met.

Continued Stay Review

Continued Stay Review is a review of your care when you are in a hospital, nursing facility, or other health facility or when you use home health services, hospice services, private duty nursing or home infusion therapy. Wellmark Blue Cross and Blue Shield of South Dakota will initiate the review.

If it is determined your current level of care is no longer medically necessary, we will notify you, your attending physician and the facility 24 hours before your benefits for services end. *Please note:* We will notify you of the date when coverage for services ends. We will not provide benefits for services received after this date.

Prior Approval

Before you receive treatment for certain services and supplies, you or your provider should request our written approval. Prior approval helps determine whether a proposed treatment plan is medically necessary, a benefit of your policy, and ensures you receive full benefits for certain services. A list of services on which we recommend prior approval can be found in your policy.

Case Management

Blue Select provides you the opportunity to receive alternative benefits to help meet health care needs resulting from extreme illness or injury. You, your physician, and the hospital can work with our case managers to identify and arrange treatment plans to meet your special needs and to assist in preserving your health insurance benefits.

Appeal Process

You may appeal any decision we make to deny or reduce benefits. The appeal process allows for a panel of physicians not previously involved in your case to perform a review of our decision. You may appeal our decision not to approve benefits, to terminate your benefits as a result of admission review or continued stay review, and our decision to reduce benefits. You may appeal by telephone or in writing. A description of the appeal process is included in your policy.



Whether you receive services from a Blue Cross and Blue Shield participating provider in South Dakota or another state, whether you live there or are just visiting, showing your Blue Cross and Blue Shield ID card (BlueCard) means you'll be treated like a member of the local Blue Plan! The "benefits" of our BlueCard Program are listed below.

1. You have the advantage of the local Blue Plan's participating provider pricing arrangements.
2. The coinsurance you pay, unless prohibited by state law, is based on the lower of the billed charge for covered services, and the "negotiated price" for covered services that the local Blue Cross and Blue Shield Plan passes on to us.
3. When receiving services from BlueCard PPO providers, you have the added advantage of having your claims processed at the Blue Select benefit level and receiving the PPO-provider negotiated price, which is typically lower than the traditional participating-provider negotiated price.

4. BlueCard PPO and other participating providers won't collect any difference between their billed charge and the negotiated price, and they'll file the claim electronically.
5. BlueCard PPO networks are available to 95% of the U.S. population. There are also BlueCard Worldwide Network hospitals in Austria, Belgium, Finland, France, Germany, Greece, Ireland, Italy, Monaco, the Netherlands, Portugal, Spain, Switzerland, and the United Kingdom. Selected hospitals in Israel, Japan, Mexico, and Uruguay also participate, as will others in the future.

When you are outside of South Dakota, just call 1-800-810-BLUE (2583) for information about the nearest BlueCard PPO providers.

prescription drugs

Advance Rx is a network of pharmacies that is owned and managed by AdvancePCS, one of the nation's largest providers of pharmacy benefits management services. You may go to any pharmacy you choose for your covered prescription drugs. Pharmacies that participate with Advance Rx will submit prescription drug claim forms for you electronically.

Many retail pharmacies in South Dakota are part of the Advance Rx network, as well as 58,000 pharmacies nationwide.* If you choose not to go to a pharmacy participating in the Advance Rx network, you will need to submit a paper claim form.

Prior Authorization

Certain drugs, listed in the Wellmark Prescription Drug Guide, are covered by your benefits policy only with prior authorization. Prior authorization allows us to verify that the drug is medically necessary and part of a specific treatment plan. Your practitioner must call us to obtain prior authorization.

Preferred Drug List

Often there is more than one medication available to treat the same medical

condition. For that reason, we have developed the Wellmark Drug List, in cooperation with AdvancePCS. It is not a required list of medications. Visit www.wellmark.com to search for a drug on the Wellmark Drug List.

When your practitioner prescribes a drug for you, you can ask that he or she refer to the comparison of prices in the Wellmark Drug List. Doing so can save you money and help control the costs of health care.

Using the Wellmark Drug List will help manage the overall cost of prescription medications by promoting the use of more cost-effective drugs. Drug manufacturers sometimes offer rebates to benefits managers such as AdvancePCS when the drugs are used in the Wellmark Drug List. We expect to receive a share of these rebates

from AdvancePCS. Any rebates we receive as a result of your prescription claims processed by AdvancePCS will be retained by Wellmark Blue Cross and Blue Shield of South Dakota and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific claims and they will not be considered when determining your benefit period deductible, coinsurance or out-of-pocket maximum.

*AdvancePCS

general provisions

Eligibility: You are eligible to apply for Blue Select coverage if you are a resident of South Dakota, under 65 years of age, and not eligible for Medicare.



Working With You, For You

It is important that you understand your Blue Select coverage to use your benefits properly:

- Present your Wellmark Blue Cross and Blue Shield of South Dakota identification card each time you receive health care services.
- Comply with the notification requirements described on page 6.
- Read your policy for complete details.

Coverage Renewability

- Coverage is automatically renewed by payment of your premium in advance.
- A grace period of 31 days will be granted for the payment of each premium due after the first premium. During this grace period, your policy will continue in force.
- We will refuse renewal of this policy only if we refuse renewal on all policies of this form and class or if you use this policy fraudulently. If we refuse to renew all policies of this form and class, we will give you 90 days written notice prior to termination. In this event, you will have the option to purchase any other health insurance coverage currently being offered by us to individuals with no additional underwriting.
- To keep the policy in force, you must pay each premium on its due date or within the grace period. We may change the premium only if we change the premium for all policies of this form and class. We have the right to change the premium rate for coverage by notifying you not less than 30 days in advance.
- When you no longer qualify as a dependent or spouse under this policy, you may obtain continuous coverage from Wellmark Blue Cross and Blue Shield of South Dakota with no additional underwriting if you apply within 31 days of the date you become ineligible.

Medicare Eligibility

When you become eligible for Medicare, you may convert to one of our Senior Blue® Medicare Supplement plans without answering health questions if you have Medicare Parts A and B and you apply during your six-month guaranteed enrollment period. This period begins the first month you are enrolled in Medicare Part B (medical insurance).

Other Information

The monthly premiums are based on the age of the oldest person covered under the policy. The following factors will be reflected in your individual rates:

- Health status of the block of business as determined by the claims experience of that block of business. The annual change due to the claims experience or health status of that block of business is limited to 15 percent.
- Individual demographics including age, gender, lifestyle, family composition and geographic area.
- The expected increase in the overall cost of health care.
- A reduced premium rate is available for persons who do not currently use tobacco products and have not used tobacco products for a minimum of 12 months.

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



You Just Can't Beat The Blues®

1601 W. Madison Street
Sioux Falls, South Dakota 57104

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