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OUTLINE OF COVERAGE

BlueSelect® Basics

SimplyBlue Health Plans for Individuals & Families

You should read your policy carefully. This Outline of Coverage for Blue Select Basics plans 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.

Premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual payment would be for January 1 through December 31 of the applicable year.

In any year in which there is a mid-year increase in the amount of premium, Wellmark will send notification of the increase. The Member will have the following responsibility with regard to an increase in premium:

Monthly Payments: Monthly payments can be made through electronic funds transfer (EFT) only. For monthly premium payments, any increase will be deducted from the member's designated account.

Quarterly Payments: Quarterly payments can be made through electronic funds transfer (EFT) only. For quarterly premium payments, any increase will be deducted from the member's designated account.

Semi-Annual Payments: For semi-annual payments, the Member will be required to pay a second semi-annual premium amount that includes the premium increase.

Annual Payment: For an annual premium payment, the Member must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

The amount of your periodic premium payment will change as provided in the policy 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, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy renewal.

If you elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. Your authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless you call or provide your bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If you call your bank to stop payment, you may be required to provide a written request within fourteen (14) days after your call. You will be responsible for any fee assessed by your bank for stop-payment orders that you make.

BlueSelect Basics

The Blue Select Basics 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 deductible, coinsurance and copayment provisions, or other limitations set forth in the policy. This coverage is available to you (“single” coverage), and to you and your family (“two-person” or “family” coverage, including your spouse and/or unmarried dependent children). You will pay the premium for coverage directly to Wellmark.

Terms to Know

Deductible

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

Family Deductible

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.

Note: MRI, PET scan, CAT scan, radiation therapy and chemotherapy are subject to deductible and coinsurance, even if performed in the office.

Coinsurance

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive certain covered services. The provider you choose affects how your coinsurance is calculated.

Coinsurance is based on:

- The payment arrangement amount minus any applicable deductible and contract limitations for all covered services provided by providers in South Dakota and Iowa.
- The local Plan’s payment arrangement amount minus any applicable deductible and contract limitations for covered services received outside of South Dakota and Iowa.

Note: MRI, PET scan, CAT scan, radiation therapy and chemotherapy are subject to deductible and coinsurance, even if performed in the office.

Office Copayment

Copayment is the specific amount you pay at the time you receive a covered service. If you have a \$30 copayment, you pay \$30 each time you go to the doctor’s office.

You are not required to pay deductible or coinsurance for most covered office services performed in a Blue Select practitioner’s office. You are only responsible for the applicable copayment. Note: Some laboratory testing performed in the office is sent outside the office for processing.

- If lab testing is sent to a Select or BlueCard PPO facility for processing, deductible and coinsurance will apply.
- If lab testing is sent to a non-Select or non-BlueCard PPO practitioner or facility for processing, deductible and coinsurance will apply.

Emergency Room Copayment

This is the specific amount you pay each time you have an Emergency Room visit instead of deductible and coinsurance. This copayment amount applies to emergency room related facility and practitioner charges. The copayment is waived if you are admitted as an inpatient to a hospital immediately following emergency room services and all charges then revert to the applicable deductible and coinsurance. This copayment does not apply toward the out-of-pocket maximum and continues after the out-of-pocket maximum is met.

Lifetime Benefit Maximum

In a covered person’s lifetime, total benefits accumulated under this policy and any other individual policy issued by Wellmark.

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 provider who does not accept our payment arrangement amount (a “non-participating” or “out-of-network” provider), or if you receive services that are subject to limitations.

Provider Savings is the amount saved due to contracts Wellmark Blue Cross and Blue Shield of South Dakota has with providers.

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 provider 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.

Balance Billing — The difference between a provider's charge and our maximum allowable fee for a specific service, procedure, or product. When you visit a non-participating network provider, you are responsible for this difference. Balance billed amounts do not apply toward your deductible or out-of-pocket maximum. You are responsible for 100% of balance billed amounts.

Plan Name	Blue Select Basics 1500	Blue Select Basics 3000
Deductible		
Single	\$1,500	\$3,000
Two-person	\$3,000	\$6,000
Family ¹	\$4,500	\$9,000
Coinsurance - You Pay		
Blue Select providers	50% except hospital inpatient services, which are subject to 25% coinsurance	50% except hospital inpatient services, which are subject to 25% coinsurance
Non-Blue Select providers	50%	50%
Out-of-Pocket Maximum (OPM)²		
Single	\$3,500 Select providers/\$7,000 Non-Select providers	\$5,000 Select providers/\$10,000 Non-Select providers
Two-person	\$7,000 Select providers/\$14,000 Non-Select providers	\$10,000 Select providers/\$20,000 Non-Select providers
Family ¹	\$10,500 Select providers/\$21,000 Non-Select providers	\$15,000 Select providers/\$30,000 Non-Select providers
Lifetime Benefit Maximum	\$5,000,000	
Office Visits³ — You Pay		
Blue Select providers	\$30 per visit per member per benefit period for the first 3 visits. Subsequent visits, you pay deductible followed by 50% coinsurance.	\$30 per visit per member per benefit period for the first 3 visits. Subsequent visits, you pay deductible followed by 50% coinsurance.
Non-Blue Select providers	Deductible followed by 50% coinsurance	
Emergency Room Copayment	\$200 per person (waived if admitted as inpatient after emergency room)	
Hospital (Inpatient)		
Blue Select providers	Deductible followed by 25% coinsurance	
Non-Blue Select providers	Deductible followed by 50% coinsurance	
Preventive and Routine Services	Covered, limited	
Maternity	Complications only	
Well-Child	Not covered up to 2 years of age	
Prescription Drugs — Blue Rx Preferred	Generic only coverage, with exceptions for contraceptives (with optional benefit), insulin, insulin-related supplies, and routine immunizations	
Benefit Period Drug Deductible	\$0	
Tier 1, (generics)	Greater of \$8 or 25%	
Tier 2	Not Covered	
Tier 3	Not Covered	
Chiropractic Care	Covered	
Mental Health and Chemical Dependency Treatment	Covered	
BlueCard (Out-of-State coverage)	Yes	
Contraceptives (optional)	Available for an additional premium (If selected, covers generic and brand name drugs)	

¹ 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 to receive benefits for covered services during a benefit period.

² Out-of-pocket maximum amounts you pay for Blue Select and Non-Blue Select network covered services apply to both the Blue Select and Non-Blue Select network out-of-pocket maximums.

³ MRI, PET scan, CAT scan, radiation therapy, and chemotherapy are subject to deductible and coinsurance and not an office copayment.

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 may be less for services from Blue Select providers
- The deductible and coinsurance are waived for office services from Blue Select practitioners up to 3 visits per member per benefit period; 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

In the event of an emergency, if you cannot reasonably reach a Blue Select provider, covered emergency care will be reimbursed as though the services were received from a Blue Select provider, subject to certain restrictions. You are responsible for any excess of the provider's billed charge over our settlement amount.

Office Visits — Blue Select Network Provider

Under our Blue Select Basics plans you are allowed a total of three Blue Select office visits per member per benefit period that apply copayment. When using a Select network provider (except for lab testing processed by either a Select or non-Select independent lab) you are responsible for:

- A \$30 copayment per visit for the first three annual covered office visits per member

For covered office visits after the first three annual office visits, you are responsible for:

- Benefit period deductible
- 50 percent of the Select network participating provider's maximum allowable fee

Office Visits — Non-Select Network Provider

When using a non-Select network provider, you are responsible for:

- Benefit period deductible
- 50 percent of our maximum allowable fee
- Any difference between our maximum allowable fee and the provider's charge (applicable to non-participating providers only)



Benefits

Approved Hospital/Health Care Facility Services

The Blue Select Basics program provides coverage for medically necessary services and supplies related to the treatment of an illness or injury when care is received 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.

Note: Even though a facility may contract with the Blue Select network, other providers within the facility, such as emergency room physicians, anesthetists, home medical equipment suppliers, and others may not contract with the Blue Select network program. It is a good idea to ask if the provider contracts with Blue Select before you receive covered services.

Facility Services

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

- Accidental injury services
- Anesthetics and their administration
- Anesthesia and hospital charges for dental care, whether services are provided in a hospital or a dental office, for a member who:
 - 1) is under age 14; or
 - 2) is severely disabled or otherwise suffers from a developmental disability as determined by a licensed physician which places such person at serious risk
- Blood administration
- Chemotherapy services
- Complications of pregnancy
- 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 and chemical dependency services
- Occupational therapy—limited to treatment of the upper extremities
- Physical therapy

- Rehabilitative speech therapy treatment (must be coordinated through home health services if provided through a home health agency)
- Rooms—including general nursing care and meals as an inpatient, or meals 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

Approved Practitioner Services

Some approved practitioners include: audiologists, 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, speech pathologists, and qualified mental health professionals. The following list describes approved practitioner services:

- Accidental injury services
- Anesthetics and their administration
- Assisting surgeon services
- Chemotherapy services
- Complications of pregnancy
- 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
- Genetic testing and counseling in certain circumstances
- Hemodialysis services
- Immunizations, annual physical, and annual gynecological exam
- 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 and chemical dependency services
- Occupational therapy for upper extremities
- One routine mammography x-ray per member per benefit period (Mammograms may be more frequent if recommended by your physician)
- Physical therapy
- Radiation therapy
- Rehabilitative speech therapy treatment (must be coordinated through home health services if provided through a home health agency)
- Routine medical care of a newborn during the mother's hospitalization
- Surgical services
- 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
- Anesthesia and hospital charges for dental care, whether services are provided in a hospital or a dental office, for a member who:
 - 1) is under age 14; or
 - 2) is severely disabled or otherwise suffers from a developmental disability as determined by a licensed physician which places such person at serious risk
- Certified diabetes education program (including insulin, insulin supplies, insulin syringes, and glucose strips)
- Home infusion therapy
- Home medical equipment — rental or purchase as determined by Wellmark
- Home skilled nursing, if given by a registered nurse (RN) or licensed practical nurse (LPN) from an agency accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager
- Oxygen and equipment needed to administer oxygen
- Most prescription drugs and medicines covered under the Blue Rx Preferred managed prescription drug program are limited to generic drugs

- Brand name and generic drugs are both covered for insulin, insulin-related supplies, routine immunizations, and contraceptives (if the optional contraceptive coverage is selected). See page 9 for additional information on your managed care drug program, Blue Rx Preferred
- Prosthetic appliances

Home Health Services

Coverage includes care provided by an agency accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and/or a Medicare-certified agency. Services must be prescribed by a physician, approved by our case manager, and not more costly than alternative services that would be effective for diagnosis and treatment of your condition. All plans include these covered services and supplies:

- Home health aide services
- Home skilled nursing, as described in “Other Covered Services” section.
- Inhalation therapy
- Medical equipment and supplies
- Medical social services
- Occupational therapy to treat the upper extremities
- Oxygen and equipment
- Parenteral and enteral nutrition
- Physical therapy
- Prosthetic appliances and braces
- Rehabilitative speech therapy treatment provided through a home health agency must be coordinated through home health services. Speech therapy benefits are not available for the treatment of certain developmental learning or communication disorders, such as stuttering and stammering

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 respite care from a facility approved by Medicare or JCAHO. Respite care offers rest and relief help for the family caring for a terminally ill patient.

Limitations

Your Blue Select Basics coverage is limited as follows:

Pre-Existing Condition Exclusion Period

A pre-existing condition exclusion 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 Basics Plans; or
- the covered person's creditable coverage was not in effect for a sufficient amount of time to satisfy the 11 consecutive month exclusion period for pre-existing conditions under this coverage. In this case, the 11-month exclusion 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 previous creditable 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
- **\$10,000** lifetime for the outpatient treatment of chemical dependency including treatment of alcoholism

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.

Weight Reduction Surgery

You are covered for weight reduction surgery provided you meet eligibility criteria for age, medical condition, and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. If you are accepted and issued coverage, you will receive a benefits policy detailing how to submit a request for prior approval. For information on the requirements to qualify for surgery, visit www.wellmark.com/WRS.

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.

Respite Care

Benefits for hospice respite care are limited to a lifetime maximum of 15 days. Benefits must be used in increments of five days or less.

Exclusions

The following services are excluded or are not considered medically necessary by Wellmark 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
- Residential treatment of mental health conditions or chemical dependency except those services received in a Residential Treatment Facility as described in the benefits policy
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders, including sex change surgery

Fertility and Infertility

- Abortion
- Collection of donor semen, oocytes, or the services of a surrogate parent
- Contraceptives (unless medically necessary to treat an illness or you purchase the optional contraceptive coverage)
- Infertility treatment
- Maternity services
- Sterilization
- Sterilization reversal
- Treatment of impotence unless it is the result of a physical illness or injury

Miscellaneous

- Anesthesia, local or topical when not billed with a surgical procedure, except anesthesia related to the provision of certain dental services as specified and limited in the policy
- Arch supports
- Blood, purchase of
- Brand name prescription drugs covered under the Blue Rx Preferred managed prescription drug program (except insulin, insulin-related supplies, routine immunizations, and brand name drugs covered under the optional contraceptive benefit if selected)
- Complications of a non-covered procedure
This exclusion does not apply to the treatment of complications resulting from smallpox vaccinations when payment for such treatment is not available through Workers' Compensation or government-sponsored programs
- Dental services except as specified and limited in the policy
- Elastic stockings and bandages
- Hearing aids and exams
- Investigational or experimental treatment as defined in the benefits policy
- Maxillary and mandibular implants

- Motor vehicles
- Non-medical services
- Personal convenience items
- Services furnished to you prior to the effective date of the policy
- Travel or lodging costs
- Treatment of temporomandibular joint disorder (TMJ)
- Vision care
- Wigs

Provider Types

- Certified registered nurses (other than an anesthetist)
- Provider is an immediate family member (exclusion does not apply in those areas in which the immediate family member is the only provider within a 30-mile radius of the provider's main office)
- Social workers, except as described in your benefits policy

Preventive and Routine Care

- Routine foot care
- Well child care

Covered by Other Programs or Laws

- 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, including any services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

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
- Rehabilitative speech therapy treatment that is not coordinated through home health services when services are received through a home health agency. 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
- 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

Notification Requirements

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

Precertification

The purpose of precertification is to determine whether a service or admission discussed below meets the medical necessity criteria of your benefits policy. 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.

Precertification is required for:

- Nursing Facility
- Acute Rehabilitation Facility
- Home Health Services
- Hospice Services
- Home Infusion Therapy
- Facilities Outside of South Dakota or Iowa

You, your Blue Select provider, or someone acting on your behalf must contact us to precertify your admission. You should call the phone number listed on your ID card.

If you do not notify us for precertification as required, the benefits may be reduced if they are medically necessary, covered benefits. They may be denied if not medically necessary or not covered under your policy. The amount of any reduction for failure to obtain authorization will not be more than \$1,000 per admission. You are subject to this benefit reduction only if you (not your provider) are responsible for notification.

Reduced or denied amounts that are the result of failure to follow proper notification requirements will not be applied to your out-of-pocket maximum.

You may appeal our decision to deny or reduce benefits.

Prior Approval

Before you receive certain services, supplies, or procedures, we recommend that you or your provider request our prior approval. Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit of your policy. Without prior approval for certain services, we cannot confirm that a proposed treatment plan is a benefit of your policy. A 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.)

For a complete list of services for which we recommend prior approval, or to ask about any other service, call the phone number listed on your ID card, or visit our Web site, www.wellmark.com.

Concurrent Review

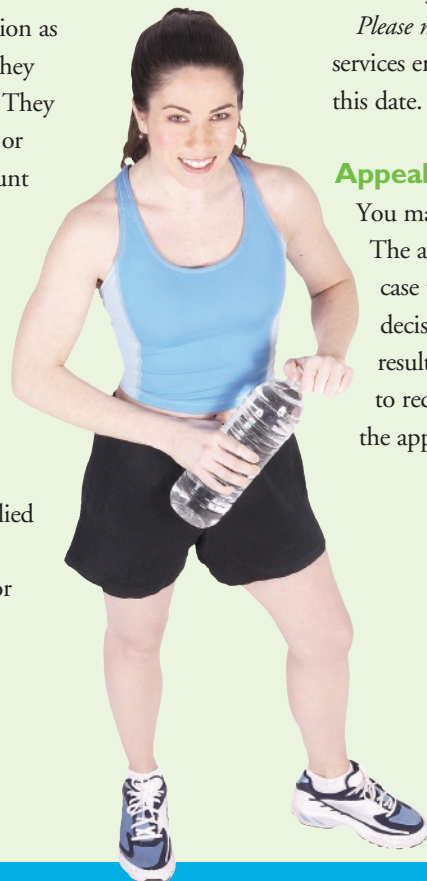
Concurrent Review is a review of your care when you are in a hospital, nursing facility, or other health facility or when you use home health services, hospice services, or home infusion therapy. Wellmark will initiate the review.

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.

Appeal Process

You may appeal any decision we make to deny or reduce benefits. The appeal process allows a panel 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 concurrent review, and our decision to reduce benefits. You must appeal in writing. A description of the appeal process is included in your benefits policy.



BlueRxSM Preferred

Only generic prescription drugs, with the exception of insulin, insulin-related supplies, and contraceptives (if you select contraceptive coverage on your application and pay the applicable monthly premium) are covered under Blue Rx Preferred, your managed drug program.

Wellmark has contracted with Catalyst Rx,[®] a full-service pharmacy benefit management company that provides integrated pharmacy benefit services to customers nationwide, to be our pharmacy benefit manager. Catalyst Rx offers nationwide access to its fully-integrated pharmacy benefit program. Wellmark members who have their prescriptions filled by any of the more than 59,000 participating pharmacies nationwide* — whether in- or out-of-state — will have their claims filed electronically by the pharmacy. In addition, network pharmacies have point-of-sale computer access to current information to screen for duplicate therapies or interactions with drugs dispensed by other network pharmacies.

Blue Rx Preferred Prescription Drug Card Plan

Blue Rx Preferred is the name of your prescription drug plan. When filling a prescription, it is important to show your Wellmark ID card to confirm that the pharmacy participates in the Catalyst Rx network that supports Blue Rx Preferred. The Rx BIN Number is on your Wellmark ID card. The pharmacist uses this Rx BIN to file your claim electronically and to determine how much you pay when picking up your prescription.

If you choose to get a prescription from a pharmacy that does not contract with Catalyst Rx, you will need to submit a paper claim to Catalyst Rx in order to receive reimbursement, and you will be responsible for any difference between the Catalyst Rx negotiated price and the pharmacy's billed charge plus any copayment or coinsurance amount.

The Blue Select Basics plans offer generic drug coverage only, with the exception of insulin, insulin-related supplies, routine immunizations, and contraceptives (if you select the optional contraceptive coverage on your application, and pay the applicable monthly premium). If you have a prescription for a brand name drug (other than insulin, insulin-related supplies, and contraceptives under the optional contraceptive benefit) you will be responsible for the entire cost of the prescription.

Covered Drugs

- Only generic prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," with the exception of insulin, insulin-related supplies (such as needles, syringes, test strips, lancets), routine immunizations, and contraceptives (if you select the optional contraceptive coverage on your application and pay the applicable monthly premium).
- Generic drugs dispensed by a pharmacist from a licensed retail pharmacy.
- Generic prescription drugs that are prescribed by a practitioner legally authorized to prescribe.
- Routine immunizations (brand and generic) when administered by a pharmacist from a licensed retail pharmacy.

Contraceptive Coverage Option

Coverage for oral contraceptives, injectable contraceptives, and contraceptive devices that are used for the purpose of preventing conception can be added to your policy for an additional premium.

Non-Covered Drugs and Services

- Brand name or branded generic drugs with the exception of insulin, insulin-related supplies, routine immunizations, and contraceptives (if you select contraceptive coverage on your application and pay the applicable monthly premium)
- Contraceptives (unless medically necessary to treat an illness or you purchase the optional contraceptive coverage)
- Cosmetic drugs
- Drugs determined to be abused or otherwise misused by you
- Growth hormones
- Impotence, except as a result of a physical illness or injury
- Investigational drugs
- Irrigation solutions or supplies
- Specialty self-administered drugs are generally covered under your health benefits policy; however, self-administered drugs for the treatment of diabetes and impotence are covered under your prescription drug program.

*Catalyst Rx, 2nd Quarter, 2007

- Most over-the-counter products, including nutritional dietary supplements; however, certain over-the-counter products prescribed by a physician may be covered as determined by Wellmark
- Self-help or self-cure programs
- Smoking cessation drugs
- Subcutaneous implants
- Therapeutic devices or medical appliances
- Weight-reduction drugs

Quantity Limitations

Drugs covered under your benefits policy may be limited per month, benefit period, or lifetime by specific quantity limitations. These limitations are determined by Wellmark based on medical necessity. For a list of drugs subject to quantity limitations, or to determine whether a drug you are taking is subject to prior authorization, visit our Web site at www.wellmark.com or check with your pharmacist or physician.

Retail Prescription Drugs

You are covered for a 30-day supply.

Refills

You may not receive benefits for a refill if sufficient time has not elapsed since the last prescription was filled. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner. You may also be denied a refill in certain circumstances. Consult your Blue Rx Preferred benefits policy for a complete list.

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 your Blue Rx Preferred benefits policy (see the Summary of Payment section). If traveling outside the United States, the refill amount will not exceed a 90-day supply.

Wellmark Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List is a list of safe and cost-effective medications that serves as a guide to physicians when deciding which medications to prescribe for their patients.

The Wellmark Drug List was developed by a local committee of physicians and pharmacists in cooperation with our contracted pharmacy benefit manager. The list suggests medications a physician might prescribe when there is a choice of medications to treat the same condition. This list is continually revised to reflect changes in the drug industry.

Physicians are not limited to prescribing only the drugs that appear on the Wellmark Drug List. Physicians may prescribe any medication, and that medication will be covered unless it is specifically excluded from your benefit policy.

Rebates

Using the Wellmark Drug List helps manage the overall cost of prescription medications by promoting the use of more cost-effective drugs. Drug manufacturers sometimes offer rebates to pharmacy benefit managers based on the inclusion of their drugs on the drug list and associated utilization. We expect to receive rebates from our contracted pharmacy benefit manager. The rebates we receive as a result of your prescription claims processed by our pharmacy benefit manager will be retained by Wellmark and applied 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 copayment or coinsurance amount.

Prior Authorization

Certain drugs, listed in the *Wellmark Drug List*, are covered by your Blue Rx Preferred 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.

You have the right to one full and fair review in case of an adverse decision in response to a prior authorization request. An adverse decision is one that denies or reduces benefits. You (or your authorized representative, if you have designated one) may appeal an adverse decision.

General Provisions

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

Coverage Renewability

- Coverage is automatically renewed by payment of your premium.
- 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. Premium changes will be reflected on your premium notice or other notification.
- When you no longer qualify as a dependent or spouse under this policy, you may obtain continuous coverage from Wellmark 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).

Medicare Enrollment

If you have become enrolled in Medicare during the term of this benefits policy, this benefits policy will provide benefits secondary to Medicare unless your employer contributes toward the premiums or otherwise sponsors this benefits policy, in which case this benefits policy may be required by federal law to provide benefits primary to Medicare.

When you become eligible for Medicare, you may convert to one of our Senior Blue[®] Medicare Supplement plans without answering health questions if you still reside in South Dakota, and you have

Medicare Parts A and B, and you apply during your six-month guaranteed enrollment period. This period begins with the first month that you are both age 65 or older and enrolled in Medicare Part B (medical insurance).

Subrogation

Once you receive benefits under your Blue Select Basics policy 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

Coordination of benefits applies when you have more than one insurance policy or plan that provides the same or similar benefits as this policy. Benefits payable under this policy, when combined with those paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount.

The method we use to calculate the payment arrangement amount may be different from your other plan's method.

Other Coverage — When you receive services, you must inform us that you have other coverage, and inform your health care provider about your other coverage. The "Filing Claims" section of the benefits policy has examples of other coverage and a list of rules of coordination.

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

Your participating or Blue Select health care provider will forward your coverage information to us. If you have a non-participating health care provider, you are responsible for informing us about your other coverage.

If the amount of payments made by us is more than we should have paid under these coordination of benefits provisions, we may recover the excess from any of the persons to or for whom we paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

Notwithstanding the foregoing provisions on Coordination of Benefits, Wellmark will always pay as though it is the primary carrier when you use your Blue Select Basics/Blue Rx ID card for prescription drugs purchased at a pharmacy.

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.

Working With You, For You

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

- Present your Wellmark identification card each time you receive health care services.
- Comply with the notification requirements described on page 8.
- Read your policy for complete details.

BlueCard®

This program, offered by all Blue Cross and Blue Shield Plans around the world, gives you a simple means to save money — no matter where you live or travel in the United States and numerous other countries. When you need medical attention, all you have to do is show your ID card to a provider who participates with the local Blues Plan.

When you use a BlueCard PPO provider:

- Most covered services you receive in the provider's office are not subject to a deductible or coinsurance. You pay the applicable copayment amount.
- You'll get Blue Plan PPO-provider negotiated prices.
- Claims subject to coinsurance will be processed at the Blue Select in-network coinsurance level.
- Participating providers have agreed not to collect from you any difference between their billed charge and the negotiated charge.
- More than 90% of all hospitals and providers throughout the United States participate with their local Blue Cross and Blue Shield Plans.*
- Participating providers and many non-participating providers will honor your ID card and file your claims for you.
- BlueCard providers do not handle notification requirements for you.

*Blue Cross and Blue Shield Association, 2007.

Whole Health Dimensions®

Helping you maintain or improve your health is important. That's why Wellmark Blue Cross and Blue Shield of South Dakota is more than just a health insurance company — we are people helping people. In support of your health care coverage, we provide programs and services with your health and wellness needs in mind.

Personal Health Assistant 24/7

Getting answers to health care questions just got easier. By calling a toll-free hotline, we can provide a direct connection to specially trained health professionals who can provide tools and support your needs.

- **Care Navigation 24/7**—provides help in locating health care resources and understanding medical treatments.
- **Nurse Support 24/7**—provides advice on urgent care concerns.

Wellness Services

One of the most important things you can do for you and your family is to protect your future health. Wellmark Blue Cross and Blue Shield of South Dakota is positioned to provide positive, proactive health management strategies and solutions.

- **Confidential Personal Health Assessment**—a web-based tool that can assist you in evaluating your health status and risk levels.
- **Online Behavior Change Programs**—web-based programs that help members take action to improve their health.

Pregnancy Care Program

Our Pregnancy Care program provides valuable information and support for moms-to-be and new mothers, from the first trimester through the early weeks of parenting. 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.

Disease Management Program

Our Disease Management program is a program that supports you and your doctor when dealing with a chronic condition. If you're diagnosed with diabetes, a cardiac condition (heart failure, coronary artery disease), asthma, or chronic obstructive pulmonary disease (COPD), you'll be invited to participate in the program. Our disease management nurse keeps your doctor informed of your progress in the program. The goal is to support and reinforce the treatment you and your doctor have established.

Complex Case Management Program

Our Complex Case Management program is designed to provide you with long-term health care needs resulting from extreme illness or injury. You, your practitioner, 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 may from time to time make available to you certain health support services (such as disease management), for a fee or for no fee. Wellmark may offer financial and other incentives to you to use such services. As part of the provision of such services, Wellmark 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's vendors, for purposes of providing such services to you. When using such information, Wellmark will do so according to the terms of Wellmark's Privacy Practices Notices, which can be accessed at www.wellmark.com/HIPAA/bipaa_privacy.htm. Wellmark may also, from time to time, make available to you certain value-added benefits for a fee or no fee. Examples include, discounts on alternative/preventive therapies, fitness, exercise and diet assistance and elective procedures, as well as resources to help you make more informed health decisions.

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.

If You Have Questions or Need Additional Information:

Please call your agent or Wellmark Blue Cross and Blue Shield of South Dakota.

We're here to help when and where you need us.

That's the difference of Blue.



An Independent Licensee of the Blue Cross and Blue Shield Association

1601 W. Madison Street
Sioux Falls, SD 57104
www.wellmark.com

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