Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

Iowa Individual, Under-65 Market Enrollment and Administrative Guide

---

Disclaimer: Wellmark, Inc. reserves the right to make changes to this guide without advance notification. To the extent that any provision in this guide is inconsistent with any provision in the benefits certificate or policy, the certificate or policy will control. This information is not considered to be, nor does it constitute, legal guidance but rather is provided for informational purposes only.

N-2304 11/06

Table of Contents

Alliance Select, Classic Blue, Blue Advantage, HSA

Description for Marketable Products

A brief description of the Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. (collectively Wellmark) products available for sale are shown below.

Direct Pay Products

Alliance Select

	Alliance Select										
	Comprehensive				Enhanced						Essential
Deductible											
Single	$300	$750	$1250	$1750	$600	$1200	$1800	$2400	$3000	$4200	$1500
Two-Person	$600	$1500	$2500	$3500	$1200	$2400	$3600	$4800	$6000	$8400	$3000
Family	$900	$2250	$3750	$5250	$1800	$3600	$5400	$7200	$9000	$12600	$4500
Coinsurance											
Select	10%				20%						20%
Non-Select	30%				40%						40%
Network Office Visit											
Deductible	Applies				Applies						Applies
Coinsurance	10%				10%						10%
Copayment	None				None						None
Annual OPM											
Single	$1300	$1750	$2250	$2750	$1600	$2200	$2800	$3400	$4000	$5200	$5500
Two-Person	$2600	$3500	$4500	$5500	$3200	$4400	$5600	$6800	$8000	$10400	$11000
Family	$3900	$5250	$6750	$8250	$4800	$6600	$8400	$10200	$10200	$15600	$16500
Lifetime Maximum	$2,000,000				$2,000,000						$2,000,000
Copayments do not apply to the deductible amount and continue after OPM has been met.											

Health Savings Account (HSA)

	Health Savings Account (HSA)	
Benefit Period Medical Deductible		
Single	$1550	$2550
Family	$3100	$5100
Coinsurance		
In network	0%	
Out-of-Network	40%	
Coinsurance In Network OPM	$1550 Single $3100 Family	$2550 $5100
Coinsurance Out of Network OPM	$3550 Single $7100 Family	$4550 $9100
Lifetime Maximum	$2,000,000	

Please refer to one of the following for complete details and coverage for health and supplemental products:

- Marketing sales material.
- Outlines of Coverage.
- Policies or Certificates.

Farm Bureau Products

Alliance Select

Product	Alliance Select											
	Gold				Silver							Bronze
Deductible												
Single	$500	$1000	$1500	$1900	$750	$1100	$1400	$1950	$2600	$3200	$4400	$2000
Two-Person	$1000	$2000	$3000	$3800	$1500	$2200	$2800	$3900	$5200	$6400	$8800	$4000
Family	$1500	$3000	$4500	$5700	$2250	$3300	$4200	$5850	$7800	$9600	$13200	$6000
Coinsurance												
Select	10%				20%							20%
Non-Select	30%				40%							40%
Annual OPM												
Single	$1500	$2000	$3500	$3900	$2000	$3000	$3400	$3950	$4600	$5200	$6400	$6000
Two-Person	$3000	$4000	$7000	$7800	$4000	$6000	$6800	$7900	$9200	$10400	$12800	$12000
Family	$4500	$6000	$10500	$11700	$6000	$9000	$10200	$11850	$13800	$15600	$19200	$18000
Lifetime Maximum	$2,000,000				$2,000,000							$2,000,000
Copayments do not apply to the deductible amount and continue after OPM has been met.												

Farm Bureau Products

Blue Advantage

Product	Blue Advantage		
Deductible			
Single	$250	$500	$1000
Two-Person	$500	$1000	$2000
Family	$750	$1500	$3000
Coinsurance			
Select	20%		
Non-Select	100%		
Annual OPM			
Single	$1250	$2000	$4000
Two-Person	$2500	$4000	$8000
Family	$3750	$6000	$12000
Lifetime Maximum	$2,000,000		

Health Savings Account (HSA)

	Health Savings Account (HSA)	
Benefit Period Medical Deductible		
Single	$1600	$2600
Family	$3200	$5200
Coinsurance		
In network	0%	
Out-of-Network	40%	
Coinsurance In Network **OPM**	$1600 Single $3200 Family	$2600 Single $5200 Family
Coinsurance Out-of-Network **OPM**	$3550 Single $7100 Family	$4600 Single $9200 Family
Lifetime Maximum	$2,000,000	

Please refer to one of the following for complete details and coverage for health and supplemental products:

- Marketing sales material.
- Outlines of Coverage.
- Policies or Certificates.

Health Savings Accounts (HSAs)

A Health Savings Account (HSA) is a savings account established exclusively for a plan member to aid the payment of medical expenses. The account accumulates funds that are contributed by the plan member. These funds can be used to pay qualified medical expenses for plan members and their spouse and dependent child(ren). Additionally, the contributions to the account are completely tax deductible and are not taxed if withdrawn to pay for qualified medical expenses.

The HSA is flexible and allows plan members to customize how they pay for health care expenses. It can help lower health care costs because it uses tax-advantaged dollars to pay for qualified out-of-pocket medical expenses.

Eligibility

The HSA is available to all applicants who are only covered under a qualified high-deductible health insurance plan. These plans have unique provisions that meet Internal Revenue Code Section 223 requirements.

Enrollment

Applicants are not automatically enrolled in the HSA through their health insurance and must establish the account with a qualified administrator, independent from Wellmark, Inc. In order to establish the HSA, the trustee or custodian will set up the HSA in the same manner as an IRA. Application, beneficiary, and custodial agreement forms are usually required.

Contributions

Plan members may make contributions to their HSA during the same tax year.

Funds in the HSA are maintained in an account and accrue interest that is credited daily to the account balance. Alternative investment options may also be provided. At the end of each year, any remaining funds may be left in the account to continue accruing interest. Accrued interest is tax-deferred.

Withdrawing Funds

The funds in an HSA belong to the plan member and can be withdrawn for any reason.

Funds withdrawn to pay for qualified medical expenses are not taxed. If funds are withdrawn for anything other than a qualified medical expense, the withdrawn funds are subject to a 10% penalty. This penalty is waived in the event of the account holder's death or disability.

When the account holder reaches the Medicare eligible age, they may withdraw funds for non-qualified medical expenses without incurring the 10% penalty.

Qualified medical expenses are medical expenses that are defined in Internal Revenue Code Section 213(d).

Supplemental Products

Life Insurance (Direct Pay Only)

Term life is an optional benefit through USAble Life and only available with the initial establishment of health benefits.

Term life may be directly billed or paid for through EFT withdrawal. If EFT withdrawal is chosen on the applicant's health coverage and the information is the same for the life insurance coverage, a separate EFT form for the life insurance coverage is not needed. If a third party is paying for the life insurance coverage through EFT withdrawal or if EFT information is not the same as the health coverage, Authorization Form M-5779 must be completed for USAble Life.

Life insurance payments will be billed and paid separately from the health coverage.

Term life is only available to the applicant and spouse. Coverage for dependent children is not offered.

Supplemental Accident

A $500 supplemental accident option is available on all underwritten marketable products except Blue Advantage or Health Savings Accounts (HSAs).

Supplemental accident may be added or canceled at any time by sending a signed request from the plan member to Station 300. The ID number must be included in the written request.

Contraceptive Coverage (Direct Pay Only)

Contraceptive coverage may be added or canceled at any time by sending a signed request from the plan member to Station 300. The ID number must be included in the written request.

Contraceptive coverage is mandated for Farm Bureau and included in their benefit program.

Optional Blue Dental Coverage

Blue Dental coverage may be selected only at initial enrollment or if a member is being added to an existing marketable product, either because of an event or with underwriting. When adding Blue Dental with a new family member, use the same application to add Blue Dental and the new member.

Blue Dental cannot be terminated without terminating the health coverage as well or changing to a different deductible amount. Members terminating coverage with Blue

Dental are not eligible to apply for the same health coverage without Blue Dental without a lapse in coverage. They must apply for a different deductible amount. Underwriting guidelines will be enforced.

Effective January 1, 2004, new dental benefits were introduced to new customers and existing Farm Bureau customers. Dental exclusion periods were added to the dental plan to keep the premiums affordable.

The following is a list of scenarios that may impact existing direct pay customers who were effective prior to January 1, 2004.

- If an existing customer is adding/removing a dependent, the customer will not be automatically moved to the post 2004 benefit unless indicated on the application.
- If an existing customer wants to change his/her deductible amount, the customer will be moved to the 2004 benefits and dental exclusion periods will be imposed, regardless of the length of time they had dental under the previous policy.
- If an existing customer is adding a dependent and choosing to add dental, the customer will be automatically moved to the 2004 benefits.
- An existing customer can apply for the same health product with the same deductible amount to upgrade to the new dental. (Example: A member may move from Enhanced 600 – pre 2004 to Enhanced 600 - post 2004.) Underwriting will not be required. Dental exclusion periods will be imposed, regardless of the length of time they had dental under the previous policy.
- On post 2004 benefit, in the event that a contract change results in splitting the contracts or a policyholder is removed from a contract due to an event resulting in a new policyholder, exclusion periods will not be applied if they were met under previous Blue Dental coverage.
- In the event that an existing customer is moving from Farm Bureau with dental exclusion periods to a Direct Pay policy with dental exclusion periods (or vice versa), new dental exclusion periods will not apply.

Existing Products No Longer Offered

For existing products no longer offered, adding a dependent without an event requires that the dependent be underwritten.

Wellmark administers these products on a direct basis with the customer and not through an agent/broker:

Direct Pay Pools

***Note*:** Refer to the member's policy/certificate or call Wellmark Customer Service for coverage details.

Direct Pay Pool 3 Products

Product	Alliance Select							Classic Blue				
	I	II	III	III-A	IV	V	V-A	VI	VII	VIII	IX MSA	X MSA
Deductible											2003 Amounts	
Single	$250	$600	$1000	$1500	$500	$1000	$1500	$1500	$2500	$5000	$1700	$2500
Two-Person	$500	$1200	$2000	$3000	$1000	$2000	$3000	$3000	$5000	$10,000	$3350	$5050
Family	$750	$1800	$3000	$4500	$1500	$3000	$4500	$4500	$7500	$15,000	$3350	$5050
Coinsurance												
Select	10%	10%	10%	10%	20%	20%	20%	N/A	N/A	N/A	N/A	N/A
Non-Select	30%	30%	30%	30%	40%	40%	40%	50%	N/A	N/A	N/A	N/A
Annual OPM												
Single	$1250	$1600	$2000	$2500	$1500	$2000	$2500	$2000	N/A	N/A	N/A	N/A
Two-Person	$2500	$3200	$4000	$5000	$3000	$4000	$5000	$4000	N/A	N/A	N/A	N/A
Family	$7500	$4800	$6000	$7500	$4500	$6000	$7500	$6000	N/A	N/A	N/A	N/A
Lifetime Maximum	$2,000,000				$2,000,000			$2000,000				

Direct Pay Pool 1 & Pool 2 Products

Product	Alliance Select					Classic Blue
	I	II	III	IV	V	VI
Deductible						
Single	$250	$600	$1000	$500	$1000	$2500
Two-Person	$500	$1200	$2000	$1000	$2000	$5000
Family	$500	$1200	$2000	$1500	$3000	$7500
Coinsurance						
Select	10%	10%	10%	20%	20%	N/A
Non-Select	20%	20%	20%	40%	40%	N/A
Annual OPM						
Single	$500	$1200	$2000	$1500	$2000	N/A
Two-Person	$1000	$2400	$4000	$3000	$4000	N/A
Family	$1000	$2400	$4000	$4500	$6000	N/A
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000

Farm Bureau Pools

Pool 3 Products

Product	Alliance Select							Classic Blue		
	A	B	B1	C	D	E	E1	F	G (MSA)	H (MSA)
Deductible									2001 Amounts	
Single	$400	$800	$1000	$1300	$600	$900	$1100	$2600	$1600	$2400
Two-Person	$800	$1600	$2000	$2600	$1200	$1800	$2200	$5200	$3200	$4800
Family	$1200	$2400	$3000	$3900	$1800	$2700	$3300	$7800	$3200	$4800
Maternity Deductible	$500	$500	$500	$500	N/A	N/A	N/A	N/A	N/A	N/A
Coinsurance										
Select	10%	10%	10%	10%	20%	20%	20%	N/A	N/A	N/A
Non-Select	30%	30%	30%	30%	40%	40%	40%	20%	N/A	N/A
Annual OPM										
Single	$1400	$2000	$2000	$3500	$2000	$3000	$3000	$5500	N/A	N/A
Two-Person	$2800	$4000	$4000	$7000	$4000	$6000	$6000	$11,000	N/A	N/A
Family	$4200	$6000	$6000	$10,500	$6000	$9000	$9000	$16,500	N/A	N/A
Lifetime Maximum	$2,000,000							$2,000,000		

Pool 1 & Pool 2 Products

Product	Alliance Select			Classic Blue
Deductible				
Single	$ 400	$ 800	$ 1300	$ 3000
Two-Person	$800	$1600	$2600	$6000
Family	$800	$1600	$2600	$6000
Coinsurance				
Select	10%	10%	10%	N/A
Non-Select	30%	30%	30%	20%
Annual OPM				
Single	$1250	$2000	$3500	$5500
Two-Person	$2500	$4000	$7000	$11,000
Family	$2500	$4000	$7000	$11,000
Lifetime Maximum	$ 1,000,000			$ 1,000,000

Long Term Care

Long Term Care products are available for sale only from independent agents specifically appointed by Wellmark to sell long term care. Long term care products are underwritten and administered by MedAmerica, a subsidiary of Excellus Health Plan in New York.

Farm Bureau agents must contact FBL Brokerage regarding Farm Bureau regulations on marketing Long Term Care products.

The Long Term Care customer service number at MedAmerica is 800-544-0327.

Other Direct Pay Programs

Health Improvement Association (H.I.A.)

Decreasing benefits is allowed anytime without answering health questions if the individual is still a resident of Iowa.

- 1 = High/High
- 2 = Low/Low
- 3 = High/Low
- 4 = Low/High

B/C Codes		B/S Codes						IM Codes		IPSC Codes
365 (H) 365 Day Comp	366 (L) 365 Day Comp 80/20 250 Max OP 100%	338 (H) UCR with unlimited DXL with Mammo	339 (I) UCR 80/20 Inpt. X-L 100% No Mammo	340 (H) UCR No DXL with Mammo	540 (L) UCR 80/20 Inpt. X-L 100% No Mammo	577 (H) UCR No DXL No Mammo	493 X-L Only with Mammo	358 STD MM with Mammo	359 STD MM Ded. Coin. On Basic not a benefit with Mammo	001 60 Days Post Hosp.

Direct Pay Groups

The following groups receive a group billing but have a bill clerk of 1000 and are maintained by the Individual Enrollment Unit:

Name	Group #—BU
Morningside Bank and Trust	06168-0000
Iowa District Assembly of God	71322-0000

For these groups:

- Adding a dependent without an event requires answering health questions. This is the only time underwriting is allowed on these plans.
- Decreasing benefits is allowed anytime without answering health questions if the individual is still a resident of Iowa.

An existing plan member on any of the groups listed above may apply for an individual plan at any time with medical underwriting.

Health Underwriting Guidelines

All new applicants are subject to complete medical underwriting.

Complete medical underwriting for anyone listed on the application requires that the applicant:

- Complete the application per instructions.
- Answer health questions and provide additional information for each numbered condition marked with a "yes" response for each person listed on the application.
- Submit the application to Wellmark within 15 days of the signature date.
- Provide additional medical information if/when requested.
    - Any cost incurred for obtaining information is the applicant's responsibility, including any cost associated with completion of the Attending Physician Statements (APSs).
- Report to Wellmark immediately any changes in health occurring after the signature date and prior to the effective date for each person listed on the application.

Regardless of medical history obtained, applications must be forwarded to Wellmark for approval. Field underwriting is not allowed.

Factors Involved in Underwriting

The following factors are considered in the underwriting process:

- Health condition of all prospective members.
    - An applicant may be informed that his/her acceptance is doubtful based on medical history, but he/she cannot be refused the opportunity to apply due to medical history.
- Height and weight of applicant and all covered dependents. Age can be a factor with certain conditions only.

Underwriting Process

The application is reviewed, and the underwriters will consider additional information and combinations of conditions in making their underwriting determinations.

If additional medical information is needed, a letter is sent to the applicant requesting specific data. If additional medical information is requested, the applicant must ensure this information is returned within 21 days of the request date.

An application that has been rejected for lack of medical information can be re-opened one time if the requested medical information is received by Wellmark within 30 days of such rejection.

The applicant may be notified if the medical information is received greater than 60 days from the signature date. Underwriting may require a signed statement from the applicant stating there have been no changes in the health of anyone listed on the application since the application was originally signed.

Underwriting Decisions

Four decisions can be made for each person listed on the application:

- Offer coverage:
    - If Underwriting accepts the applicant and family members if applicable, identification cards and policies/certificates are mailed to the member within 10 days of processing.
- Offer a pre-existing condition amendment:
    - The applicant has 14 days to accept and return the pre-existing condition amendment. If the amendment is not returned within 14 days, Underwriting will reject the applicant.
    - If the applicant accepts the pre-existing condition amendment by signing and returning it within 14 days, treatment for the medical condition(s) listed on the amendment will be excluded.
    - If the amendment is not returned, coverage will not be issued.
    - An existing pregnancy is considered a health condition and a nine-month exclusion period is applied by adding an amendment.
    - Pre-existing condition amendments remain in effect even if applicant has 12 months qualifying previous coverage.
- Offer a rate up or enrollment in an alternative benefit plan.
    - The applicant has 14 days to accept and return the offer. If the offer is not returned within 14 days, Underwriting will reject the applicant.
    - If an applicant or a family member is offered a rate up, Wellmark will split the plan:
        - The individual impacted will be established on his/her own plan with a rated up premium.
        - The rest of the family members will be on a separate plan that is not rated up.
        - If the family does not want the plan split due to the rate up, Wellmark must be notified with the submission of the rated up amendment.

- Reject applicant or a family member (person exclusion)
    - Any services for individuals who have been offered a total exclusion amendment will not be covered.
    - If Underwriting rejects the applicant or family member, a letter is sent to the applicant notifying him/her of the rejection. Any submitted premiums will be applied to the existing plan or refunded accordingly.
    - Coverage may be available through HIPIOWA, a state-sponsored program.

HIPIOWA Information

If an applicant has had no qualifying previous coverage or has had qualifying previous coverage and has been denied or will not accept the condition amendment and/or person exclusion, the applicant *and his/her family* may be eligible to enroll in a plan offered by HIPIOWA. They must meet the eligibility requirements for these plans.

However, the remaining family members with acceptable medical history may continue the underwriting process after removing the affected person from the application.

See HIPIowa for more information.

Appeals

An applicant may appeal an amendment or rejection by completing and submitting Request for Review of an Existing Amendment form, P-5342, to:

Wellmark Blue Cross and Blue Shield of Iowa
Medical Underwriting – Station 19
P.O. Box 9232
Des Moines, Iowa 50306-9232

Underwriting responds to an appeal when an applicant wishes to dispute the amendment or rejection he/she has received. Updated medical information is always required for these reviews. The underwriter responds directly to the applicant following the review process.

Removal of Condition Amendments or Person Exclusions

Wellmark does not automatically review amendments for removal. It is the responsibility of the member to request a review.

If a member has accepted coverage with an amendment(s), he/she may request a review after two years or after the amendment removal date indicated on the amendment letter.

- The member must complete form Request for Review of an Existing Amendment, P-5342, and send to the Underwriting Department at the address listed in the previous section.

- Updated medical information and completion of a Certificate of Health Status will be required.
- All written communication regarding status of a request for review of an amendment will be handled directly with the member or applicant.

Failure to Disclose (FTD)

Claims are reviewed for two years following the effective date in case an applicant did not list a pre-existing medical condition on their application.

If an applicant fails to disclose a medical condition on an underwritten application for which coverage would have been denied (either as a person exclusion, pre-existing condition amendment or as a rate up) and a claim is incurred within two years of the effective date of the policy/certificate, the claim will be investigated.

The investigation process is as follows:

- Wellmark will request all internal documents on the covered member.
- Wellmark will request submission of medical records from the medical professional filing the claims in question.
- Upon review of records, the member is offered a person exclusion, pre-existing condition amendment or a rate up. The member must make a decision whether he/she will accept within 14 days of the offer.
- If the member **accepts** an exclusion, pre-existing condition amendment or rate up:
    - The policy/certificate will be amended as of the original effective date.
    - Any additional premium required must be submitted for a rate up.
    - If an exclusion results in a type of contract change (for example, family to two-person or single), there will be a refund of a portion of premium paid, if applicable.
    - If the amendment and/or any additional premium needed for a rate up are submitted within 14 days, coverage will continue with the addition of the new amendments. Wellmark will need to recover money for benefits paid for an excluded condition.
    - These individuals may request to have their amendments reviewed in two years according to standard operating procedures.
- If the member **does not accept** an exclusion, pre-existing condition amendment or rate up, Wellmark determines if failure to disclose exists and, if it does:
    - The plan will be terminated as of the original effective date.
    - All premiums paid on the plan will be refunded minus any amount of claim(s) previously paid. If claims paid exceed the premium paid, no refund will be

made and the former member must return any claim payments made in excess of the amount of premiums paid.

    - If claim payments exceed the amount of premium recouped and the member does not return claim payments, the Wellmark Legal Department reserves the right to file legal action against the member.

- Policies/certificates that have been terminated for Failure to Disclose are not eligible for reinstatement. The canceled member cannot reapply for individual coverage for a five-year period.

Eligibility

Wellmark requires all new applicants to be under 65, a resident of Iowa, and meet additional eligibility requirements described in this section.

Definition of Eligible Members

In the case of a single or one-person contract, coverage is provided for the applicant only. For family contracts of two or more persons, eligible members are defined as:

- Applicant.
- Applicant's spouse by legal marriage or common law marriage.
- Applicant's dependent child(ren) who is(are) a natural child, a stepchild, a foster child, a legally adopted child (or a child placed with the applicant for adoption) or a child for whom the applicant has been appointed legal guardian. Dependent child(ren) must be unmarried and:
    - Under the maximum allowable age for dependent children of 19; **or**
    - Totally and permanently disabled, either physically or mentally. The disability must have existed prior to the dependent reaching the maximum allowable age or while the dependent was a full-time student. Proof of disability may be required; **or**
    - A full-time student. A full time student is a dependent enrolled in high school or an accredited institution of higher learning, such as a college, university, nursing, trade, beauty, business or other specialty school. The number of hours required per semester for a full-time student is based on the school's definition, although this is generally 12 hours or more.

      Students taking classes from an accredited Internet college must provide evidence of a definite start date and progress toward a definite finish date. They also must maintain a minimum of 12 credit hours.

      Students involved in an accident or suffering from a serious illness that prohibits them from attending school may continue coverage for four months if proper medical documentation is submitted. Medical documentation must be updated each semester (or quarter, term, etc., depending upon the school's method of dividing the year). The student will remain an eligible dependent as long as the institution lists them as enrolled.

Requirements

Residency

- The applicant must be an Iowa resident.
    - Wellmark reserves the right to require reasonable evidence that a prospective insured is a resident of Iowa.
    - Factors that may be considered include a driver's license, voter registration, and place of residence.
    - Proof of residency may include a recent property tax statement, property liability/casualty insurance statement, monthly utility statement in the proposed insured's name or a copy of a signed lease agreement.

Other Coverage

- An applicant cannot be eligible for Medicare due to disability, whether enrolled in Medicare or not.

Contract

- All immediate family members (applicant, spouse, and eligible dependents under age 18) must be covered under the same contract. Wellmark requires family members to be covered under the same contract to reduce the risk of adverse selection.
- Dependents age 18 and older may apply for a single contract or may be included on a family application.
- If the application is for family members not covered under an existing contract, the family members not currently covered must be added to the existing contract, unless the dependent is age 18 or older and chooses to apply for a single contract. All underwriting criteria will apply.
- Dependent children may apply for coverage under a child(ren) only contract
    - if they are not enrolled in or eligible for Wellmark individual coverage under a parent's or legal guardian's contract. See "Completing the Application" section.

Product

- Existing members enrolled in plans no longer sold may apply for new products. The following applies:
    - Applications are subject to medical underwriting and any applicable exclusion periods.
    - For further information, please refer to the Product Movement Charts under "Decreasing Benefits" and "Farm Bureau Benefit Change Underwriting Table Movement within Currently Marketed Farm Bureau Products" in the "**Error! Reference source not found.**" section.

- Blue Advantage is only available to Farm Bureau members in counties with Blue Advantage providers. To find the most current information, access http://www.wellmark.com/e_business/pdf/whpisa.pdf.

Restrictions

- Applicants who are not United States citizens are not eligible for Direct Pay or Farm Bureau since the coverage is guaranteed renewable. See "Short Term Major Medical, Eligibility."
    - Foreign exchange students cannot be added to the host family's existing plan.
- A small group (2-50) employer cannot pay a member's premiums (any portion of or fully). This rule is applicable to groups who also offer Section 125 benefits. The following are exceptions:
    - The applicant is owner of a sole proprietor business.
    - The employer has only one eligible employer.
    - The employer is withholding the full premium from the employee's compensation. All premiums being withheld are the employee's money.
    - The employer has been denied the opportunity to purchase insurance due to low participation/contribution regulations as defined by Wellmark. (A copy of the denial is required.)
    - Small employer is located out of state - not covered by Iowa Code Chapter 513B.
    - Individual who does not meet the definition of "eligible employee" as established by Iowa Code Section 513B.2 and by Wellmark (for example, an employee who works less than 15 hours per week).

Exclusion Periods

Wellmark applies exclusion periods for all pre-existing conditions at the policy/certificate level. Pre-existing conditions are any illness or injury, or any medical, surgical or other condition (including a mental health condition, chemical dependency or pregnancy) that existed before a benefits policy became effective. The duration of an exclusion period is 365 days from the date the policy/certificate goes into effect.

When Exclusion Periods are Waived

- Upon initial enrollment, exclusion periods are waived when at least one person covered by the policy/certificate has had 12 months of qualifying previous coverage.
- If a member is added to an existing policy/certificate because of an event or with medical underwriting, exclusion periods will be waived for all members on the contract if the new member has 12 months of previous qualifying coverage.
- If one parent has had 12 months of qualifying previous coverage on a Child(ren) Only contract covering just a child less than one year of age, the exclusion period will be waived.

When Exclusion Periods Apply

- Upon initial enrollment, if no one covered by the policy/certificate has had qualifying previous coverage, a 12-month pre-existing condition exclusion period is applied.
- When a member is added to an existing policy/certificate with an event or by medical underwriting, exclusion periods may apply if the existing members are in the process of meeting applicable exclusion periods and the new member has not had 12 months of previous qualifying coverage.
    - For example, if the existing members have completed six months of the exclusion period, the new members have the remaining six months of exclusion period applied.

Receiving Credit for or Reductions in Exclusion Periods

- Exclusion periods will be reduced when an application for Short Term Major Medical coverage is **received with** an under 65 underwritten application. Credit is given for the length of time covered under the Short Term Major Medical coverage.

Qualifying Previous Coverage

Health Insurance Included in Qualifying Previous Coverage

Wellmark allows qualifying previous coverage that includes any combination of the following types of health insurance that provide benefits equal to or greater than benefits provided under the Standard Benefit Health plan. The qualifying previous coverage must have been in effect for 12 months (with no more than a 63-day lapse in coverage prior to the application signature date or submission date for electronic applications).

- Employer groups, including fully insured and self-funded groups.
- Group conversion.
- Health benefits sponsored by private insurers in foreign countries.
- Individual.
- HIPIOWA, previously Iowa Comprehensive Health Association (ICHA).
- Organized Delivery System.
- Peace Corps.
- Secure Blue and Secure Blue Select.
- Wellmark - ISU Student Group.

Health Insurance Not Included in Qualifying Previous Coverage

Non-qualifying previous coverage includes the following types of insurance:

- Blue Care.
- FEP.
- *hawk-i*.
- Health coverage sponsored by a foreign government or a political subdivision.
- Health coverage while incarcerated.
- Indemnity.
- Long-term care.
- Medicaid (Title 19).
- Medical provisions under a property casualty policy.
- Medicare.
- Medicare supplement.
- Short Term Major Medical.
- Specific disease insurance, such as cancer policy.
- TRICARE (formerly Champus).

Effective Dates

For New Applicants

Two effective date options are available when completing the application – the applicant can choose an effective date or the applicant can allow Wellmark to determine the effective date.

When neither option is chosen, Wellmark will assign an effective date based on the underwritten approval date. See "Option II" section below.

Eligibility for coverage begins on the member's effective date unless the member is in the hospital or other inpatient facility. In that case, the coverage begins the day after the member's discharge from the hospital.

Option I

The agent assigns an effective date.

- The applicant may request any effective date up to 60 days following the date the application is signed.
    - The effective date must be a date after the signature date (not to include the date the application is signed).
- Preferred effective dates are the first or 15th of the month, allowing at least 30 days from Wellmark's receipt to process the application.
- If an application is returned to the Direct Pay agent or Farm Bureau county office or service center because the application or forms are not completed correctly, Wellmark will honor the requested effective date. However, the applicant must re-date the application.
- All policies must have a first of the month premium due date after establishment of the initial effective date.
- No money should be sent with the application.
- Applicants will be charged premium from the effective date requested on the application.

Option II

Wellmark assigns the date:

- If the application is medically approved the first of the month through the 15th of the month, the assigned effective date will be the first of the month following approval. (For example, if the application is medically approved on September 13, the effective date assigned will be October 1.)

- If the application is medically approved the 16th of the month through month end, the assigned effective date will be the first of the second month following approval. (For example, if the application is medically approved on July 20, the effective date assigned will be September 1.)

If an applicant desires an effective date other than the first or 15th of the month, this request must be indicated on the original application. Underwriting will assign the month.

Changing Effective Dates on New Applications

An application's effective date can be changed on an application prior to an Underwriting process completed status by written request if all of the following conditions are met:

- The requested new effective date is not earlier than the signature on the application; and
- The requested new effective date is within 60 days of the signature date; and
- The requested new effective date is not earlier than the date requested on the application.

The applicant does not need to show proof of other coverage.

An application's effective date can be changed on an application in an Underwriting process completed status if the requested new effective date is within 60 days of the application signature date whether or not the application is set up, if all of the following conditions are met:

- The requested new effective date is not earlier than the signature date on the application; and
- The requested new effective date is later than the effective date requested on the application (Option I) or the assigned effective date (Option II) and the change is being requested because the customer had other coverage in effect and can provide proof of this duplicate coverage. This documentation must be in writing from the other carrier; and
- The requested new effective date will not be changed to be earlier than the date the request was received.

For Members Changing Existing Coverage

- The effective date of the contract changes must be the first of the month. See "Changes to Existing Membership" for effective date information regarding eligible events.
- If a member needs to request an effective date other than the first of the month, the effective date will be changed to the first of the month following the requested date.
- Changes to existing policies/certificates are usually the first of the month following the signature date. However, a member may elect to be effective the first of the

second month following the signature date. An effective date other than the first of the month following the signature date must be noted in the effective date box on the application.

- During a rerate only, a member may have an effective date that is earlier than the date the application is signed. The application must be signed during the month of rerate and the requested effective date must be on the application. (For example, if the rerate effective date is January 1, and the application to change plans is signed on January 15 with an effective date of January 1 requested on the application, Wellmark will change the policy effective date to January 1.) This only applies to changing benefits. It does not apply for adding or removing dependents.
- If it is not noted the member wants an effective date to coordinate with the rerate, Wellmark will assume the change is to be effective the first of the month following the signature date.
- If a member submits a request to add/remove a dependent due to a qualifying event and requests a change in benefits including optional benefits, the effective date for benefit change would be the first of the month following notification.
    - However, when adding dental to an existing contract with an event or underwriting, dental will be added the date the member was added to the contract.

Electronic Application

A member or agent may also apply for individual or family coverage online at www.wellmark.com. The electronic application may be used for:

- Determining what a policy will cost.
- Submitting an application.

It is the fastest and easiest way to complete and submit an application or provide a health insurance shopper with an idea of what a policy will cost.

At this time the electronic application is for new business only. Changes to existing individual membership must be submitted on a paper application.

Agent Registration

An agent must be registered to access the system. The registration process can also be completed online by going to the drop down menu of the Brokers & Agents Corner, selecting "Register Now," and following the instructions.

A User's Manual specifically for electronic sales, marketing products, and enrollment procedures is available once an agent has registered. Please refer to this manual for any question related to the electronic application process.

Paper Applications - Marketable Products

Paper applications may be obtained from Office Services or through wellmark.com.

A properly completed application will provide the necessary information for an efficient underwriting and enrollment process.

General Guidelines

- Write legibly (printing is advised). Ink is required. Do not use pencil.
- Read each section's instructions carefully. Not all sections need to be completed for every applicant.
- Before signing application, the applicant must read the Authorization and Certification and Notice to Applicant Regarding Replacement of Accident and Sickness Insurance sections.
- Before submitting application, review the checklist on the front cover to make sure all steps have been completed properly.
- If a current Wellmark customer with individual coverage has an out-of-state mailing address but is a resident of Iowa and the address on Wellmark's membership files is the same as that on the application, "IA resident" must be written on the top of the application.

Section A: Membership Information

- Indicate Farm Bureau membership number (Farm Bureau only). An applicant applying for Farm Bureau coverage must have a Farm Bureau membership number.
- Indicate Farm Bureau County number where the Farm Bureau agent is located (Farm Bureau only).
- Leave the group billing unit number and monthly premium amount blank.
- Indicate whether the application is being completed for New Enrollment or for Changes to Existing Coverage.
- For Option I, fill in the effective date. For Option II, leave this field blank.
- Indicate marital status.
- Complete the name, address, and Payor's name and billing address (if different from applicant's address) in full.
    - The first address line requires the applicant's street address. The address indicated in this line is where all correspondence such as Attending Physician Statements, Benefits Policies/Certificates, and Identification cards will be sent.
    - The second address line is for the Payor's billing address. This line should be completed if the premium statements should be sent to a separate address. All

other correspondence will be sent to the applicant's address indicated in the first address line.

    - In rural areas applicants may have a residential address but only receive mail at a PO Box. If this is the case, please indicate this information by adding both the residential and PO Box address.

- List all persons to be covered:
    - If this is a child(ren) only contract, list the oldest child first.
    - If all dependents on a child(ren) only contract are 18 or older, they can use same application or submit separate applications.
- Complete the birth date, Social Security number, height, weight, sex, full-time student age 19 and over and disabled sections for each person to be covered on the policy/certificate.
- If the disabled question is marked "Yes," be sure to answer the "Is disabled person eligible for Medicare?" question.

Section B: Enrollment Information

- If using this application to make a change to existing coverage, indicate "Yes" or "No" for whether applicant is maintaining current health product.
- If the applicant is new member or a current member changing plans, place a check in the box in front of the benefit plan desired.
- Check "Yes" or "No" for each optional benefit.
- The applicant must initial any altered benefit plans or optional benefits.
- If the member is making a change to existing coverage, make certain the event, affected party, and the date of the event is listed.
- Answer "Yes" if anyone listed on the application has used tobacco products during the past 12 months.
    - If the answer is "Yes," list the name and relationship of the user.
- If a small group employer is paying the premium for an employee's health coverage (referred to as employer contribution), Wellmark cannot write the application due to regulations under Iowa Code 513B, unless one of the reasons listed is marked.

Section C: Health Questions

- Each health question must be answered "Yes" or "No."
- For any numbered medical question answered "Yes," furnish complete details about the health condition. If necessary, include additional pages.
- The applicant must initial any health questions altered from "yes" to "no."

Section E: Prior Coverage/Other Coverage

- Indicate whether or not applicant (spouse or dependent children, if applicable) has had prior coverage or will maintain other coverage in addition to this policy/certificate.
- If the applicant (spouse or dependent children, if applicable) has had prior coverage, list complete details of that coverage.
    - This section determines if exclusion periods will be waived.
- If the applicant will retain other coverage, list complete details of that coverage.
    - This section will determine coordination of benefits provisions.

Section F: Life Insurance

- Direct Pay: If payor for life insurance did not sign the application, pre-authorization form (M-5779) is needed.

Section G: Payment Arrangement

- Indicate how the applicant wants to be billed – Direct Billed or Automatic Account Withdrawal.
- For either method, indicate frequency of withdrawal.

Section H: Agreement and Certification

- Required signatures, as applicable, include:
    - Applicant, if not a minor.
    - Parent/Legal Guardian, if applicant is a minor.
    - On a child(ren) only contract, all dependents over 18 and, if minor children are also listed on the same application, a parent's signature is required.
- The applicant must indicate the current date. The date must be changed if the application is returned for missing information.
- The agent must sign and date the application.
- Complete the full agent number.

What to Attach to the Application

Attach the following, if applicable, to the application:

- Preprinted voided check, if applicable.
- A completed Authorization form, P-5343, if applicant wants to authorize agent access to protected health information for the purpose of completing the application for insurance and pre-enrollment underwriting process.

Where to Send the Application

- Applications requiring underwriting must be forwarded within 15 calendar days of the signature to Station 300.
- Other applications and supporting documents must be forwarded within 15 calendar days of the signature to:

  Wellmark Blue Cross and Blue Shield of Iowa
  Station 300
  P.O. Box 9232
  Des Moines, Iowa 50306-9232

Note: In order to record applications being submitted and conduct a screening process, contracting agencies may require appointed agents to submit applications through their centralized system.

Rating

Wellmark rates are based on the age of the oldest member covered under the policy/certificate as of the effective date of the contract.

- Single policies are gender rated.
- Tobacco users are charged higher premiums.
- Cost for optional benefits are added to the premium.

Age Rating – Marketable Products

Multiple age bands exist. The age bands will be recalculated on the date the policy/certificate is rerated, when a member requests a benefit change, or when a plan member adds or deletes a spouse or dependent.

Single male, single female, married, one child, two children, three or more children rates are available.

Age Rating – Existing Products No Longer Offered

Single, two-person, and family rates are available. Medicare Dependent and Minor Dependent rates are available for an existing plan member, his or her spouse, and/or dependents.

Tobacco Declaration

Wellmark requires all applicants and members covered by a policy/certificate to answer tobacco declaration questions to determine if tobacco or tobacco non-user premiums apply. Tobacco use includes both smoking and chewing.

Tobacco rates are applied at the contract level. For tobacco users, use the tobacco user premium tables.

Existing Members

Existing plan members need to notify Wellmark by submitting written documentation (Tobacco Declaration, form M-5749) if:

- A declared tobacco user becomes and remains tobacco free for 12 consecutive months.
- Anyone on the contract begins to use tobacco.
- The tobacco user is removed from the contract after enrollment.

Any differences in premiums due to the above changes will be effective the first of the month following receipt of notification by Wellmark.

Premium Payment Options

Premiums should not be submitted with the application. If premium is submitted with the application, it will be deposited immediately by Wellmark but does not constitute guaranteed coverage as applicant is subject to approval by Medical Underwriting.

Modes of Payment

Two modes of payment are available:

- Direct Billed.
- Electronic Fund Transfer (EFT).

Frequencies

Four frequencies are available:

- Monthly—EFT only.
- Quarterly.
- Semi-Annually.
- Annually—Available to Direct Pay only.

If direct billed quarterly, semi-annual or annual frequency is elected, future premium due dates will be on the first of the month.

All billings are on a calendar year cycle, regardless of the original effective date of coverage.

EFT Requests

When EFT is requested:

- First or fifth of the month withdrawal is available.
- Checking or savings account withdrawals are allowed.
    - If checking is indicated, attach a preprinted voided check.
    - If savings account is indicated, completion of an Authorization for Automatic Account Withdrawal, form M-5779, which requests the bank account numbers and phone number of the financial institution, is required.
- For life insurance, if the payor has not signed the application, attach Authorization for Automatic Account Withdrawal, form M-5779.

Wellmark will prorate the initial bill so future premium due dates will be either the first or fifth of the month for EFT.

A new authorization form must be signed anytime a premium will be withdrawn from a different account number. Wellmark must receive notification by the 10th of the month in order for the request to be processed by the next billing period.

However, in case of bank buyouts, Wellmark may be directly notified of the account revisions by the financial institution.

Changes to Existing Membership

Wellmark requires timely notification when a member needs to be added or removed from an existing policy/certificate due to any of the following events.

Events Not Requiring Underwriting

Underwriting will not be required if Wellmark receives appropriate notification within 60 days of the following events:

- Adoption or placement for adoption of a child.
- Birth of a child.
    - Birth of a sibling to add newborn to a Child(ren) only contract.

Underwriting will not be required if Wellmark receives appropriate notification within 31 days of the following events:

- Change in dependent child status.
    - Marriage.
    - 19th birthday, unless a full-time, unmarried student.
    - No longer a full-time student (over age 19).
    - No longer totally and permanently disabled (over age 19).
- Death of a plan member.
- Death of a spouse or dependent.
- Dependent resuming student status.
- Dissolution of marriage or legal separation.
- Eligible for and obtains coverage from employer.
- Eligible for and obtains coverage under Veteran Affairs (VA).
- Foster child.
- Legal guardianship.
- Marriage or declaration of common law.
- Medicare enrollment requiring a contract split.
- Military service suspension.

Additionally, Wellmark will not require any remaining children to underwrite when the oldest child is removed from the contract.

Events Requiring Underwriting

Underwriting will be required for the following:

- If the notification is submitted beyond 31 days of the eligible event, except for the notification of the birth or adoption of a child.
- If the notification is submitted beyond 60 days for the birth or adoption of a child.
- Dependents over age 18 or a full-time student over age 19 who choose to come off their parent's contract without an event.
- Spouse/Dependents who move to contracts with a better benefit offering (i.e., decreasing deductible within the same plan option, moving to a plan option that has increased benefits) than they had prior to the eligible event.
- Spouse/Dependents who move to a currently marketable product from an existing product that is no longer offered that they had prior to the eligible event.
- Addition of a natural child under an Iowa Medical Child Support Order – when the plan member is required by a court order to cover his/her child(ren).
- If a former dependent is changing from Direct Pay to Farm Bureau (or vice versa) or increasing benefits, the dependent's spouse would also need to underwite.

Effective Date of Change

The effective date for those changes that are received in a timely manner are listed in the table that follows.

The effective date for those changes received beyond 31 days of the event (or 60 days when the event is the birth or adoption of a child) will be the first of the month following signature date on application. See chart for exceptions.

Requirements

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information
Adoption of a Child	Within 60 days of adoption or placement in home for purpose of adoption	First of the month in which physical custody takes place; if physical custody within 60 days of birth, first of the month of birth	Signed application and adoption petition filed to District Court and/or documentation on letterhead from attorney/adoption agency with: • Plan member's name • Plan member's ID number • Child's full name • Child's date of birth • Date the adoption petition was filed or will be filed or the date the adoptive parents were awarded physical custody	• Grandparents may cover a grandchild only if they legally adopt the child. • If the adoption does not occur, the plan member is responsible for repaying any of the child's claims paid by Wellmark.

Birth of a Child	Within 60 days of the birth	First day of the month in which the birth occurs or first day of the month following birth	Direct Pay: Signed application
			
			Farm Bureau: Refer to the benefits certificate.
				• Birth of a child is not event to add spouse and/or other dependents not currently enrolled; they may submit application for underwriting.
				• Birth of a dependent's child is not an event for a dependent to be removed from a parent's contract and establish own contract without underwriting.
				  • Dependent may remain on parent's contract.
				  • Dependent's child may underwrite for a single policy.
				  • Dependent's child may only be added to grandparent's contract if grandparent has adopted child or has legal guardianship.

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information

Change in Dependent Child Status	Within 31 days of the events that causes dependent child to become ineligible. See "Eligible Events."	First day of the month following the change in status
		
		When canceling a member via the Dependent Status Validation letter, dependent will be canceled based upon the preprinted date (first of the month following dependent's birthdate) on the Dependent Status Validation letter.
			Application required to remove dependent from contract.
			Note: Dependent Status Validation letters are sent yearly to determine whether dependent maintains student status. If letter is returned stating dependent no longer a student, dependent will be canceled based upon the preprinted date (first of the month following dependent's birthdate). If letter is not returned, dependent will be canceled.
				• If applying for a plan with same or lesser benefits within same pool:
				  • Credit will be give for satisfaction of exclusion periods under parent's policy.
				  • Dependent's spouse will not need to underwrite if effective date is prior to the marriage. If marriage occurs prior to the effective date of the policy, the new spouse will require medical underwriting.
				  • Any existing amendments will apply.
				  • Any amount met toward deductible and coinsurance does not transfer over to the new policy when the policyholder is changed.
				• See "Dependent Status Due to Disability" section at end of this table.

Death of a Plan Member	Within 31 days of the death	Single policy: Day after the death of plan member
		Family policy: First of the month following date of death.
			Single policy: Written documentation. See "Cancellations".
			Family Policy: If family wishes to maintain policy, a signed application will need to be submitted.
				• Any premiums paid beyond the termination date will be refunded to the plan member's estate.
				• If surviving spouse/dependent apply for coverage:
				  • Any amendments and exclusion periods to be satisfied will apply.
				  • Any amount met toward deductible and coinsurance will transfer over to the new policy.

Death of a Spouse or Dependent	Within 31 days of the death	First of the month following the date of death	Signed application.	Any premium paid beyond the change date will be refunded or applied to the policy still in existence.

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information
Dependent Resuming Student Status	Within 31 days of the dependent resuming full-time student status	First of the month the event occurs or first day of the month following the event	A signed application	• Underwriting will be required if family moved to greater benefits or from an old pool to a currently marketable product while dependent was not covered. • Any pre-existing condition amendments that the dependent had previously on their parent's policy will be applied.

Dissolution of Marriage (Divorce) or Legal Separation	Within 31 days of the event which is the "file" date stamped on the divorce	First of the month following the "file" date	Divorce: Application; if a divorce decree is received with an application requesting removal of spouse, the spouse's signature is not needed; otherwise, both member and spouse will need to sign application.
			
			Legal Separation: Application with a copy of separation indicating legal separation file date (Usually plan member continues to cover spouse in cases of legal separation. The act of filing for dissolution of marriage does not constitute a legal separation.)
				• If spouse applies for continuous coverage with the same (or lesser) benefits within the same pool:
				  • Any dependent covered on the original policy can be covered.
				  • Any pre-existing condition amendments apply.
				  • Any unsatisfied exclusion periods apply.
				• Any amount met toward deductible and coinsurance does not transfer to new policy when policyholder is changed.
				• A child of divorced parents cannot be double covered under both their parent's individual contracts.
				• If notification to remove the spouse is received outside of the 31 days, the spouse will be canceled first of the month following the divorce and will be subject to underwriting.
				• Members signing a common law affidavit must file for and legally obtain a dissolution of marriage to be considered divorced.
				• Divorce is considered an event to remove dependents, i.e., stepchildren, from policy.

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information
Eligible for and Obtains Coverage from Employer	Within 31 days of the event	First day of the month following the event; if event falls on first of the month, that will be the effective date	Family policy: Signed application and: • Name of person obtaining employer group coverage • Employer name • Carrier name • Effective date of the employer group coverage	• Any amendment or exclusion periods will apply to the remaining family member(s). • Any amount met toward the deductible and coinsurance will transfer to new policy when the policyholder is changed. • The plan member or spouse cannot choose to take part of remaining family to employer group and leave part on the individual plan.
Eligible for and Obtains Coverage under Veterans Affairs	Within 31 days of the event	First of the month following the event; if event falls on first of the month, that will be the effective date	Single policy: Written notification; see "Cancellations" Family policy: Signed application	• Any amendment or exclusion periods will apply to the remaining family member(s). • Any amount met toward the deductible and coinsurance will transfer to new policy when the policyholder is changed.
Foster Child	Within 31 days of the event	First day of the month in which the child enters the home of the plan member	Signed application and a copy of legal documentation that includes: • Plan member's name • Plan member's ID number • Child's full name • Child's date of birth • Date the child enters the home	N/A
Legal Guardianship	Within 31 days of the event	First day of the month in which the court makes the appointment	Signed application and a copy of legal documentation that includes: • Plan member's name • Plan member's ID number • Child's full name • Child's date of birth • Date the court appointed legal guardianship	• Grandparents may cover a grandchild only if the court appoints the grandparents as the child's legal guardians.

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information
Marriage or Declaration of Common Law	Within 31 days of the event Event date for common law marriage is date specified on affidavit that couple began living as husband and wife	Marriage: Effective date must be noted on application. If effective date is not noted, it will be assigned as follows: • If member signs application before first of month of marriage, the first of the month of marriage. • If member signs application after first of month of marriage, the first of the following month.	Marriage: Signed application Common Law Marriage: Both parties must sign and submit a notarized "Affidavit-Common Law Marriage."	• Only a new spouse and his or her dependents may be added without underwriting. • If anyone on the policy has had qualifying previous coverage, exclusion periods are waived. • If combining two single individual policies, the couple may choose to enroll in either existing plan. • If adding a spouse and the plan member is underwriting to increase benefits, the spouse must also underwrite.

Medicare Enrollment Requiring a Contract Split	Within 31 days of the Medicare enrollment date	The date the Medicare Supplement policy becomes effective	Application	• Underwriting will not apply if continuing the same benefits or applying for lesser benefits within the same pool.
				• Any amendments and exclusion periods will apply to remaining family members.
				• This Medicare Dependent coverage (Pools 1 – 3 only) is available to a spouse not eligible for Medicare and unmarried, dependent children of a Medicare-eligible member.
				  • Parent eligible must be enrolled in Wellmark Senior Blue coverage
				  • Available only to members in older pools.

Event	Notification Date	Coverage Effective Date	Notification Form(s)	Additional Information

Military Service Suspension	Within 31 days of the date the member begins basic training or is called to active military service	The date the member begins basic training or is called to active military service	If individual policy, family policy with all members requesting military suspension or family policy with spouse or dependent requesting military suspension:
			Written documentation requesting suspension of coverage and a copy of military papers indicating date of entry
			Family policy (only policyholder requesting military suspension):
			Application and Written documentation requesting suspension of coverage and a copy of military papers indicating date of entry
				• The individual should confirm eligibility with the military before requesting military suspension.
				• If it is not possible for an individual policyholder to submit written notification, other options are available:
				  • Phone call is acceptable
				  • Information accepted from someone other than policyholder, i.e., a parent for a son/daughter's policy. Additional written documentation needs to indicate relationship to policyholder.
				• Individual policy: Failure to contact Wellmark within 31 days of the event date will result in ineligibility for placing on military suspense.
				• A policy is not eligible for military suspension if the family member entering the military is not on the contract.
				• Subscribers entering the Peace Corps is not an event to suspend coverage.
				• See "Reinstatement following Military Service Suspension" information below.

Dependent Status Due to Disability

A dependent is considered disabled if he/she is totally and permanently disabled either physically or mentally and is unable to seek gainful employment. He or she must also require some assistance with activities of daily living.

For verification of disability status, Individual Enrollment must have answers for the following questions:

- Is the dependent a full-time student?
    - If yes, the dependent is not eligible for disability status. He/she will remain as student status on the contract.
- Was the dependent disabled prior to his/her 19th birthday or while a full-time student?
    - If yes, Medical Underwriting will verify disability status and re-evaluate when appropriate.

If a dependent is disabled temporarily while a full-time student after his/her 19th birthday and he/she cannot attend school, he/she will remain on a full-time student status until the end of the school semester in which the disability began. At that time, he/she must move to coverage in his/her own name or apply for a permanently disabled dependent status.

If the temporary disability becomes a permanent disability while covered under the parent's plan, Wellmark reserves the right to re-evaluate the situation.

Note: If the dependent currently has Medicare, the Medicare number and effective dates of Medicare Parts A and B must be provided.

Reinstatement following Military Service Suspension

A plan member may reinstate their plan within 120 days of separation from the military service, being placed on inactive status, or termination of military health coverage.

- A copy of military papers indicating the date of discharge or inactive status and an application to request to reinstate coverage must be forwarded to Wellmark.
- The effective date will be the date of discharge or inactive status from the military service.
- The plan member will be responsible for all premiums due from the reinstatement effective date.
- If Wellmark does not receive papers within 120 days of separation from the military service, being placed on inactive status or termination of military health coverage, the plan member will need to reapply for coverage and will need to be medically approved through medical underwriting.

A dependent who was a full-time student prior to the military suspension is allowed to reinstatement on their parent’s policy.

- They will be considered an eligible dependent as long as they resume full-time student status by the next available start date with an accredited institution of higher learning.
- If they do not resume full-time student status, they will no longer be eligible for the contract the first of the following month after reinstatement.
- An application for the same policy or one with lesser benefits would need to be submitted within 120 days from this termination date in order to bypass medical underwriting.

If the person was single upon entering the military and married while serving in the military, the spouse and any dependents of the spouse will be covered without medical underwriting on the reinstated plan.

- Exclusion periods will apply only if the plan member had not satisfied them previously.
- If the spouse and dependent(s) being added had qualifying previous coverage without a 63-day break in coverage, exclusion periods are waived.

Cancellations

Cancellations can be requested by a plan member or initiated by Wellmark for specific reasons. Cancellations requested by plan members should be submitted not less than 30 days in advance of the requested cancellation date.

Right to Review and Return Policy

Upon receipt of the policy and ID cards, a plan member has the right to review the policy and return it with the ID cards to Wellmark and cancel the policy as never effective.

- This right must be exercised within 10 days of the plan member's receipt of the policy and ID cards.
- A full refund of paid premium will be issued, if applicable.
- In the event the member returns the policy, the member is responsible for reimbursing Wellmark for any claims paid by Wellmark.
- Wellmark has the right to recover any claims they may have paid pursuant to the returned policy.
- The right to review and return policy does not include the right to change benefits or add/remove optional benefits.

Cancellations Requested by Plan Member

Plan members may cancel their policies by providing the following written documentation:

- The plan member's name whose coverage is being canceled.
- The plan member's ID number.
- The plan member's signature or signature of legal guardian or person with Power of Attorney (POA). If the Power of Attorney is not on file with Wellmark, it must be submitted with the cancellation.

If a plan member notifies Farm Bureau/Direct Pay agents or a service center and insufficient time remains to mail in the cancellation request, a copy may be faxed to Wellmark Individual Enrollment, 515-248-5309.

If a plan member requests cancellation and subsequently requests reinstatement, the policy can be reinstated only if the request is received within 10 days of the cancellation process date or prior to the cancellation date.

Cancellation Effective Date

The cancellation effective date will be the first of month following Wellmark's receipt date, provided the cancellation request is received prior to the requested cancellation date.

For example:

Requested Cancel Date	Wellmark Receipt Date	Cancellation Date
May 1	April 20	May 1
July 18	July 9	August 1
September 1	September 10	October 1
October 1	October 1	November 1
November 20	December 12	January 1

Retroactive Cancellation Dates

Retroactive cancellation dates will be honored only for those enrolling in a Wellmark employer group or HIPIOWA if notification is received within 63 days of the effective date of coverage:

- For those members who become covered under a Wellmark employer group (either as an employee or a dependent of an employee)
    - The member must request cancellation.
    - See "Eligible for and Obtains Coverage from Employer."
- For members who become covered under HIPIOWA:
    - No claims have been paid during the retroactive period.
    - A copy of the HIPIOWA welcome letter showing the date the letter was mailed and the effective date of the HIPIOWA contract must be forwarded to Wellmark.

Requests to retroactively cancel policies for those who obtain coverage from another carrier will not be honored. Cancellations will be effective the first of the month following receipt of the request.

Cancellations Initiated by Wellmark

Coverage will terminate at 11:59 P.M., Central time, on the last day of the month for any of these reasons:

- The member fails to pay the monthly premium by the end of the grace period.
- For Farm Bureau underwritten products, the policyholder fails to maintain their membership in the Iowa Farm Bureau Federation.
- The policy is used fraudulently or the member fraudulently misrepresented or concealed material facts in the application. If this happens, Wellmark will recover any claim payments made minus any premiums paid.

- Wellmark decides to terminate coverage of all similar policies by giving written notice to all members 90 days prior to termination. In this event the policyholder will have the option to purchase any other health insurance coverage currently being offered by Wellmark to other individuals with no additional underwriting.

Payment Changes and Premium Refunds

Automatic Account Withdrawal

It is the member's responsibility to make the following payment changes:

- Members who pay premiums via automatic account withdrawal and who cancel their coverage must notify Wellmark in writing by the 10th of the month to have their request processed for the next billing period.
- It is the member's responsibility to make financial arrangements for the next withdrawal or to contact his or her financial institution and place a stop payment on the withdrawal. The cost of the stop payment is the member's responsibility.

Wellmark will only process requests to change from automatic account withdrawal to direct bill when the request is submitted in writing.

Premium Refunds

Wellmark will refund any premium that the member has prepaid following the month of termination. Refunds are usually sent by the 20th of the month following cancellation.

Questions can be referred to a Wellmark marketing representative or broker account manager.

Cancellation/Reinstatement for Nonpayment

EFT plan members are subject to the following guidelines:

- If Wellmark receives notice of insufficient funds, Wellmark Enrollment will forward a letter to the plan member requesting appropriate premium payment within 31 calendar days.
- Wellmark will cancel a member after receiving two notices of insufficient funds during a 12-month period.
- If canceled for nonpayment, two reinstatements will be allowed for nonpayment of premium per 12-month period.
- Once the plan is terminated, the plan member must complete an underwritten application if he/she wants individual coverage. He/she will be treated as a new applicant, and new exclusion periods may be applied.

Direct Billed plan members are subject to the following guidelines:

- A final pay notice will be forwarded when a payment is more than 15 days past due.
- A termination notice will be produced 31 days following the due date and the plan will be retroactively canceled.
- A plan member wishing to reinstate must send a reinstatement request and payment to Wellmark within 31 days of the termination notice.
- Two reinstatements will be permitted within a 12-month period.
- If the plan is terminated for the third time, the plan member must complete an underwritten application. He/she will be treated as a new applicant and new exclusion periods may be applied.

Inter-Plan Transfer Program

The Inter-Plan Transfer Program makes it possible for an existing Wellmark Blue Cross and Blue Shield of Iowa or Wellmark Health Plan of Iowa, Inc. (collectively Wellmark) plan member to continue his/her coverage after he/she moves to another BCBS Plan area. This program was developed to offer plan members the option of receiving continuous coverage by the Plan serving the geographical area where the plan member lives and is most likely to obtain hospital and medical care. The Plan area in which the plan member resides determines coverage options and eligibility regulations.

Coverage may be transferred to the state where the plan member lives.
Policies/certificates must be in a prepaid status (minimum of 60 days) before they may be transferred.

Transfers Into Iowa

- Applicants must be residents of Iowa.
- Plan member will be subject to full medical underwriting and approval.
- An effective date must be indicated on the application. Wellmark will verify the termination date with the prior Plan.
- All applications should be sent to:

  Wellmark Blue Cross and Blue Shield of Iowa
  Medical Underwriting
  Station 300
  P.O. Box 9232
  Des Moines, IA 50306-9232

- If the prior Plan notifies Wellmark indicating the plan member has moved to Iowa, Wellmark will send a packet for Direct Pay coverage options to the member.

Transfers Out of Iowa

Plan members leaving Iowa and transferring to another BCBS Plan are subject to the coverage, rates, and underwriting requirements determined by the new BCBS Plan. If Wellmark is notified of the transfer, a notification is sent to the new Plan. However, it is the plan member's responsibility to contact the new BCBS Plan for that information.

Wellmark members are not forced to transfer out of Iowa. However, the following applies:

- No benefit changes are allowed for plan members residing outside of Iowa.
- Spouse or dependents can only be added due to an event (i.e., marriage or birth). A spouse or dependent can not be added with underwriting.
- Farm Bureau members must maintain an active Farm Bureau membership.

Benefit Changes

When requesting a benefit change, members should not cancel their current individual policy. When the new benefit is activated, the old benefit will be canceled or membership will contact the member requesting cancellation notification.

Increasing Benefits or Changing Pools Requires Underwriting

All applications for an **increase** in the level of benefits or for changing pools, i.e., moving from a non-marketable plan to a currently marketable plan, are **subject to medical underwriting** by Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. (collectively Wellmark).

Requirements

- The plan member must still be a resident of Iowa.
- The tobacco declaration section on the application must be completed.
- All health questions must be answered.
- All optional benefits and the appropriate plan desired must be indicated.
    - Life insurance cannot be added when increasing benefits or changing pools. It can, however, be maintained.
    - Blue Dental cannot be added if the plan member is increasing benefits and is covered by a currently marketable plan without Blue Dental.
    - Blue Dental can be maintained if it is in effect.
    - Blue Dental can be elected when changing pools.
    - Blue Dental can be canceled when moving to a different deductible amount in the same pool.

Effective Dates

Applications approved to increase benefits will have an effective date of the first of the month following the signature date or the first of the second month following the signature date.

Exception: An application to increase benefits may be signed during the month of rerate and may have the first of the month of rerate for an effective date. This effective date must be noted on the application.

Request for Increased Benefits Rejected, Offered Pre-existing Condition Amendment or Rated Up

If rejected, or offered pre-existing condition amendment(s) or person exclusion(s), or rated up, the present level of benefits may be retained. All family members must retain

the same level of benefits (i.e., those who pass underwriting cannot move to the increased benefits and leave other family members on the existing level of benefits).

Decreasing Benefits

Applications for a decrease in the level of benefits may be submitted at any time without medical underwriting. Requests are limited to the customer's current pool of business.

Additional requirements include:

- The plan member must still be a resident of Iowa.
- The tobacco declaration section on the application must be completed.
- All optional benefits and the appropriate plan desired must be indicated.
    - Life insurance cannot be selected. It can be maintained if already in effect.
    - Blue Dental can be selected only if the member is decreasing benefits from a plan with Blue Dental.
    - Blue Dental can be canceled when moving to a different deductible amount in the same pool.

Effective Dates

All applications to decrease benefits will have an effective date of the first of the month following the signature date or the first of the second month following the signature date. The effective date cannot be retroactive.

Exception: An application to decrease benefits may be signed the month of rerate and have the first of the month of the rerate for an effective date. This must be noted on the application.

Direct Pay Benefit Change Underwriting Table Movement within Currently Marketed Direct Pay Products

		DESIRED PLAN																								
		COMPREHENSIVE								ENHANCED									Essential		HSA		CLASSIC BLUE		
		Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004									Pre 2003	Post 2003
CURRENT COVERAGE		300	300	750	750	1250	1250	1750	1750	600	600	1200	1200	1800	1800	2400	3000	4200	1500	2500	1550	2550	3000	5000	5000
COMPREHENSIVE	300 pre2004		No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	300 post2004	NA		NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	750 pre2004	NA	UW		No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	750 post2004	NA	UW	NA		NA	No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1250 pre2004	NA	UW	NA	UW		No UW	NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1250 post2004	NA	UW	NA	UW	NA		NA	No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1750 pre2004	NA	UW	NA	UW	NA	UW		No UW	NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1750 post2004	NA	UW	NA	UW	NA	UW	NA		NA	No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
ENHANCED	600 pre2004	NA	UW	NA	UW	NA	UW	NA	UW		No UW	NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	600 post2004	NA	UW	NA	UW	NA	UW	NA	UW	NA		NA	No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1200 pre2004	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW		No UW	NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1200 post2004	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA		NA	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1800 pre2004	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	1800 post2004	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA		No UW	No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	2400	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW		No UW	No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	3000	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW		No UW	No UW	No UW	No UW	No UW	NA	NA	NA
	4200	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW		No UW	No UW	No UW	No UW	NA	NA	NA

		DESIRED PLAN																								
		COMPREHENSIVE								ENHANCED									Essential		HSA		CLASSIC BLUE		
CURRENT COVERAGE		Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004	Pre-2004	Post-2004									Pre 2003	Post 2003
		300	300	750	750	1250	1250	1750	1750	600	600	1200	1200	1800	1800	2400	3000	4200	1500	2500	1550	2550	3000	5000	5000
Essential	1500	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW		No UW	No UW	No UW	NA	NA	NA
	2500	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW		UW	No UW	NA	NA	NA
HSA	1550	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW	No UW		No UW	NA	NA	NA
	2550	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW	No UW	UW		NA	NA	NA
CLASSIC BLUE	3000	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW	No UW	UW	No UW		NA	NA
	Pre 2003 5000	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW	No UW	UW	No UW	HA		NA
	Post 2003 5000	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	NA	UW	UW	UW	UW	UW	No UW	UW	No UW	NA	NA	

Movement within Direct Pay Pool 3

Current Coverage	Desired Plan											
	Plan I	Plan II	Plan III	Plan III-A	Plan IV	Plan V	Plan V-A	Plan VI	Plan VII	Plan VIII	Plan IX	Plan X
Plan I		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan II	N/A		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan III	N/A	N/A		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan III-A	N/A	N/A	N/A		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan IV	N/A	N/A	N/A	N/A		No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan V	N/A	N/A	N/A	N/A	N/A		No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan V-A	N/A	N/A	N/A	N/A	N/A	N/A		No U/W	No U/W	No U/W	N/A	N/A
Plan VI	N/A	N/A	N/A	N/A	N/A	N/A	N/A		No U/W	No U/W	N/A	N/A
Plan VII	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		No U/W	N/A	N/A
Plan VIII	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
Plan IX	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Plan X	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Movement within Direct Pay Pool 1 & 2

Current Coverage	Desired Plan					
	Plan I	Plan II	Plan III	Plan IV	Plan V	Plan VI
Plan I		No U/W	No U/W	No U/W	No U/W	No U/W
Plan II	N/A		No U/W	No U/W	No U/W	No U/W
Plan III	N/A	N/A		No U/W	No U/W	No U/W
Plan IV	N/A	N/A	N/A		No U/W	No U/W
Plan V	N/A	N/A	N/A	N/A		No U/W
CB-5000	N/A	N/A	N/A	N/A	N/A	

N/A=Not Available

Farm Bureau Benefit Change Underwriting Table Movement within Currently Marketed Farm Bureau Products

CURRENT COVERAGE		GOLD				SILVER							BRONZE		HSA		CLASSIC BLUE			BLUE ADVANTAGE		
		500	1000	1500	1900	750	1100	1400	1950	2600	3200	4400	2000	3300	1600	2600	CB-HSA	2500	4000	250	500	1000
GOLD	500		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1000	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1500	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1900	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
SILVER	750	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1100	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1400	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	1950	UW	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	2600	UW	UW	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	3200	UW	UW	UW	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	4400	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
BRONZE	2000`	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW		No UW	No UW	No UW	No UW	No UW	No UW	UW	UW	UW
	3300	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW		UW	No UW	UW	UW	UW	UW	UW	UW
HSA	1600	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	No UW		No UW	No UW	No UW	No UW	UW	UW	UW
	2600	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	No UW	UW		No UW	No UW	No UW	NA	NA	NA
CLASSIC	CB 2500-HSA	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	No UW	UW	No UW		No UW	No UW	UW	UW	UW
	2500	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	No UW	UW	No UW	No UW		No UW	UW	UW	UW
	4000	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	No UW	UW	UW	No UW	No UW		UW	UW	UW
WHPI	250	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW		No UW	No UW
	500	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW		No UW
	1000	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	UW	

Movement within Farm Bureau Pool 3

Current Coverage	Desired Plan									
	Plan A	Plan B	Plan B1	Plan C	Plan D	Plan E	Plan E1	Plan F	Plan G	Plan H
Plan A		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan B	N/A		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan B1	N/A	N/A	N/A	No U/W	No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan C	N/A	N/A	N/A		No U/W	No U/W	No U/W	No U/W	N/A	N/A
Plan D	N/A	N/A	N/A	N/A		No U/W	No U/W	No U/W	N/A	N/A
Plan E	N/A	N/A	N/A	N/A	N/A		No U/W	No U/W	N/A	N/A
Plan E1	N/A	N/A	N/A	N/A	N/A	N/A		No U/W	N/A	N/A
Plan F	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A
Plan G	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Plan H	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

Movement within Farm Bureau Pool 2

Current Coverage	Desired Plan						
	AS 400	AS 800	AS 1300	ValuCare	CB 2500	FB 1	FB 2
AS 400		No U/W	No U/W	N/A	No U/W	No U/W	No U/W
AS 800	N/A		No U/W	N/A	No U/W	No U/W	No U/W
AS 1300	N/A	N/A		N/A	No U/W	No U/W	No U/W
ValuCare	N/A	N/A	N/A		N/A	N/A	N/A
CB 2500	N/A	N/A	N/A	N/A		N/A	N/A
FB 1	N/A	N/A	N/A	N/A	N/A		No U/W
FB 2	N/A	N/A	N/A	N/A	N/A	N/A	

Movement within Farm Bureau Pool 1

Current Coverage	Desired Plan						
	HL/EL/EL+	AS 400	AS 800	AS 1000	CB 2600	FB 1	FB 2
HL/EL/EL+		No U/W	No U/W	No U/W	No U/W	No U/W	No U/W
AS 400	N/A		No U/W	No U/W	No U/W	No U/W	No U/W
AS 800	N/A	N/A		No U/W	No U/W	No U/W	No U/W
AS 1000	N/A	N/A	N/A		No U/W	No U/W	No U/W
CB 2600	N/A	N/A	N/A	N/A		N/A	N/A
FB 1	N/A	N/A	N/A	N/A	N/A		No U/W
FB 2	N/A	N/A	N/A	N/A	N/A	N/A	

N/A=Not Available

Secure Blue (Standard), Secure Blue Select (Standard PPO), and Blue Care (Basic)

Existing Products No Longer Offered

Product	Secure Blue℠	Secure Blue Select℠		Blue Care®
		Select Providers	Non-Select Providers (separate deductible)	
Deductible				
Single	$1000	$1000	$1000	$1500
Two-Person	$2000	$2000	$2000	$3000
Family	$3000	$3000	$3000	$4500
Coinsurance	20%	20%	40%	40%
Office Visit Copayment	N/A	$20	$40	N/A
Annual OPM				
Single	$3000	$3000	$4000	$6300
Two-Person	$6000	$6000	$8000	$12600
Family	$7000	$7000	$9000	$18900
Lifetime Maximum	$1,000,000	$1,000,000		$250,000

Secure Blue Select Notes:

- Copayments do not apply to the deductible amount and continue after the OPM has been met.
- Benefits for services received from both Select and non-Select providers contribute toward both the Select and non-Select OPMs.
- Secure Blue Select uses the Alliance Select provider network. Pharmacies are not Alliance Select providers. Therefore, benefits are at the non-Select level.

Eligibility

Since January 1, 2005, Basic and Standard Plan options have not been available for new sales nor have existing members been able to make benefit changes.

Wellmark will continue to administer existing Basic and Standard plans. This includes making contract changes due to eligible events, e.g., adding a dependent due to birth or marriage, changing policyholder due to Medicare eligibility, and allowing dependents who are no longer full-time students to become single policyholders.

HIPIOWA Information

If an applicant is denied for underwritten coverage due to health conditions or is offered a condition amendment or rate up, the applicant may be eligible for coverage under Health Insurance Program of Iowa (HIPIOWA). A general description of eligibility requirements for HIPIOWA is available at www.hipiowa.com or by calling 877-793-6880.

Prior to HIPIOWA, it was Wellmark's policy that if the policyholder had an event (such as receiving a rate increase or receiving amendments) to move to a Basic or Standard plan option, the remaining family members would not need to underwrite to continue coverage on their own. Wellmark will consider the situation the same when a policyholder obtains HIPIOWA; the remaining family members will not be required to underwrite.

Miscellaneous Information

- Unmarried dependents that are full-time students are covered until age 25.
- If the plan member is adding a member due to marriage, they may not add maternity coverage. Maternity coverage may be elected only at initial enrollment.
- A member who currently has a Secure Blue, Secure Blue Select or Blue Care policy can enroll in a group and still continue with his/her Secure Blue, Secure Blue Select, or Blue Care policy. When he/she becomes a left employee of the employer group, the member may elect COBRA and also continue his/ her Secure Blue, Secure Blue Select or Blue Care policy. Benefits paid under the group coverage or COBRA will not be duplicated under Secure Blue, Secure Blue Select or Blue Care.
- A member who currently has a Secure Blue, Secure Blue Select or Blue Care policy may enroll in Medicare and continue his/her Secure Blue, Secure Blue Select or Blue Care policy. Medicare will be prime.

Exclusion Periods

Wellmark applies exclusion periods for all pre-existing conditions at the policy level. Pre-existing conditions are any illness or injury, or any medical, surgical or other condition (including a mental health condition, chemical dependency or pregnancy) that existed before a benefits policy became effective. The applicant will have an exclusion period of 365 days from the date the policy goes into effect. See "Qualifying Previous Coverage."

Effective Dates for Existing Applicants

Existing Applicants

An application submitted within 31 days of qualifying events will be effective as of the date of the qualifying event. These include:

- Medicare eligibility.
- Adding a dependent due to birth.*
- No longer an eligible dependent.
- Divorce.
- Marriage.
    - Maternity coverage cannot be added to the policy with the addition of a new spouse.

*When adding a dependent due to birth or adoption, the application must be submitted within 60 days.

Rating

Wellmark rates are based on the age of the oldest member covered under the policy as of the effective date of the contract.

- If any members use tobacco products, there is an additional charge for their health plan. For tobacco users, use the tobacco user premium tables.
- Cost for optional benefits must be added to the premium.

Rates Types Available

- Single male, single female, 2-person, family, Medicare dependent rates are available.
    - If any members use tobacco products, there is an additional charge for their health plan. For tobacco users, use the tobacco user premium tables.
    - Cost for optional benefits must be added to the premium.
- Medicare Dependent and Minor Dependent rates are available.

Short Term Major Medical (STMM)

Description for Marketable Products

In order to provide immediate Wellmark coverage for members, a Short Term Major Medical (STMM) policy is available for issuance that does not require medical underwriting.

- Applicants may choose to be covered for a minimum of 30 days to a maximum of six months.
    - If the member would like additional coverage after the first policy expires, a new application must be completed for a second issuance.
- Pre-existing conditions are not covered under this policy, and it is not considered to be qualifying previous coverage under Iowa law.

Short Term Major Medical

Product	Short Term Major Medical		
Deductible Per Policy Term			
Single	$250	$500	$1000
Two-Person	$500	$1000	$2000
Family	$ 750	$1500	$3000
Coinsurance	20%	20%	20%
OPM Per Policy Term			
Single	$1000	$1500	$3000
Two-Person	$2000	$3000	$6000
Family	$3000	$4500	$9000
Lifetime Maximum	$1,000,000	$1,000,000	$1,000,000
Extension of Benefits	12 months	12 months	12 months

Please refer to one of the following for complete details and coverage for the Short Term Major Medical products:

- Outline of Coverage.
- Policy.

Eligibility

Definition of Eligible Members

In the case of a single or one-person contract, coverage is provided for the applicant only. For family contracts of two or more persons, eligible members are defined as:

- Applicant.
- Applicant's spouse by legal marriage or common law marriage.
- Applicant's dependent child(ren) who is(are) a natural child, a stepchild, a foster child, a legally adopted child (or a child placed with the applicant for adoption) or a child for whom the applicant has been appointed legal guardian. Dependent child(ren) must be unmarried and:
    - Under the maximum allowable age for dependent children of 19; **or**
    - Totally and permanently disabled, either physically or mentally. The disability must have existed prior to the dependent reaching the maximum allowable age or while the dependent was a full-time student. Proof of disability may be required; **or**
    - A full-time student. A full time student is a dependent enrolled in high school or an accredited institution of higher learning, such as a college, university, nursing, trade, beauty, business or other specialty school. The number of hours required per semester for a full-time student is based on the school's definition, although this is generally 12 hours or more.

      Students taking classes from an accredited Internet college must provide evidence of a definite start date and progress toward a definite finish date. They also must maintain a minimum of 12 credit hours.

      Students involved in an accident or suffering from a serious illness that prohibits them from attending school may continue coverage for four months if proper medical documentation is submitted. Medical documentation must be updated each semester (or quarter, term, etc., depending upon the school's method of dividing the year). The student will remain an eligible dependent as long as the institution lists them as enrolled.

Applicant Requirements

- The applicant must be an Iowa resident.
    - Wellmark reserves the right to require reasonable evidence that a prospective insured is a resident of Iowa.
    - Factors that may be considered include a driver's license, voter registration, and place of residence.

    - Proof of residency may include a recent property tax statement, property liability/casualty insurance statement, monthly utility statement in the proposed insured's name or a copy of a signed lease agreement.
- Full-time students who are considered residents of Iowa may apply for STMM if attending a school out-of-state.
- Citizens of foreign countries, including foreign exchange students residing in Iowa, may apply for STMM since it is a limited term policy.

Restrictions

Policies cannot be issued if any member listed on the policy:

- Is not a resident of Iowa.
- Is younger than 15 days old.
- Is a dependent child over age 19 and not a full-time student.
    - If the dependent is a full-time student, the dependent may remain on the contract up to age 23.
- Is eligible for Medicare or Medicaid or will reach age 65 during the term of coverage.
- Is seeking coverage for the sole purpose of traveling outside of the United States.
- Has been treated, diagnosed or been advised to seek treatment within the last five years for:
    - Heart or circulatory system disorder including hypertension and high blood pressure;
    - Stroke;
    - Diabetes;
    - Cancer or tumor;
    - Alcohol abuse;
    - Drug abuse or chemical dependency; or
    - Immune system disorder including acquired immune deficiency (AIDS) or AIDS Related Complex (ARC) and/or has tested HIV positive.
- Is pregnant (including a spouse or dependent who is pregnant).
- Has been declined for health insurance due to health reasons within the last five years.

Issuance Restrictions

- The plan member can only have two issue periods.
    - The second issuance does not have to be for the same policy term as the first issuance. (For example, the first issuance policy term could be for three months and the second could be for five months.)
    - There must be a six-month break in coverage after the second Wellmark issuance before the same applicant may again apply for an STMM policy.
    - Deductible and out-of-pocket maximums met under the first policy period will not be carried over to the second period.
    - Any illness or injury that occurred during the first policy term will be considered a pre-existing condition and will not be covered under a second policy term.

Effective Dates

New and Existing Applicants

Effective dates for Short Term Major Medical can never be:

- Earlier than the day after the application signature date; or
- Later than 60 days following the signature date of the policy.

Odd effective dates are allowed. Termination dates may be odd dates except for those paying by EFT which would require a first of the month termination date.

Term of Coverage

Coverage is available for a minimum of 30 days to a maximum of six months, in one-month increments.

- For customers choosing to pay premiums via EFT, policies must terminate at the end of a month.
- If the customer's effective date is other than the first of the month and they choose a six-month term, the policy term may not exceed six months.

It is possible to purchase an "odd" number of days of coverage.

- See the "Odd Effective Date Rate Table" section to determine the rate for the odd number of days.

Pre-existing Conditions Not Covered

Treatment for pre-existing conditions is not covered under Short Term Major Medical coverage.

A pre-existing condition is defined as any illness, injury or other condition that you or your family members received, or were advised to receive, treatment or advice within 12 consecutive months before the effective date of the policy.

- This includes any condition that existed on the effective date of the policy, and any condition which progressed, developed from, was a complication of, or was secondary to any illness, injury or other condition existing on the effective date of this policy.
- This also includes any condition which would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within 12 months before the effective date of the policy.

Additional provisions include:

- Pre-existing conditions will not be covered for any members added to the policy due to an event.
- Any health condition(s) that may have arisen during the first term of coverage will be considered pre-existing under any second term and will not be covered.

Completing the Application

Electronic Application

Access Wellmark.com to complete an electronic application.

Paper Application

General Information

- Write legibly (printing is advised). Ink is required. Do not use pencil.
- Complete every item in each section. If something does not apply, write "N/A."
- The application must be signed and dated by the applicant, not a spouse.
- The agent must sign and date the application.

Eligibility Checklist

- Complete all questions.
    - A policy cannot be issued if there is a "yes" response to any of these questions.

Membership Information

- Complete dependent data on ALL members to be covered.

Policy Type Information

- Indicate:
    - Type of policy: Single, two-person or family.
    - Policy term: Enter effective and termination dates.
        - Applicants can choose to be covered for thirty days to six months.
        - The effective date can never be earlier than the application signature date or later than 60 days after the date the application is signed.
        - Other than 1st of the month effective and termination dates: Coverage can begin other than the first of the month and will end at 12:01 a.m. on the same day of the termination month. (For example, if a three month issuance is chosen with an effective date of March 5, the policy will terminate at 12:01 a.m. on June 5.)
    - Deductible plan: $250, $500 or $1000 plan.
    - Complete the section on how the premium is going to be paid.

- Premium submitted: Please refer to the premium schedule in the STMM packet.
- Indicate first or second issuance.

Employer Contributions

- Complete both questions.

Agent and Applicant Signature

- The applicant must sign and date the application.
- The agent must sign and date the application. The agent number must be listed on the application.

Rating

Rates are based on the age of the oldest member covered under the policy as of the effective date of the contract.

- Single policies are gender-rated.
- Single, two-person, and family rates are available.
- Short Term Major Medical policies do not have different premiums for tobacco users.

Payment Options

Requirements

Full payment must be received with the application unless the customer chooses to pay premiums via Electronic Fund Transfer (EFT).

Restrictions

A small group employer (2-50) cannot pay a member's premium (any portion of or fully). This rule is applicable to groups who also offer Section 125 benefits. The following are exceptions:

- The applicant is owner of a sole proprietor business.
- The employer has only one eligible employee.
- The employer is withholding the full premium from the employee's compensation. All premiums being withheld are the employee's money.
- The employer has been denied the opportunity to purchase insurance due to low participation/contribution regulations as defined by Wellmark. (A copy of the denial is required.)
- Small employer is located out-of-state – not covered by Iowa Code Chapter 513B.

Mode of Payment

Two modes of payment are available:

- Direct Billed. The entire premium for the term selected must be submitted with the application.
- Electronic Fund Transfer (EFT) — Monthly payment option only.

Additional Requirements for EFT Requests

When EFT is requested:

- If the payor is not listed on the application, attach "Authorization for Automatic Account Withdrawal," form M-5779.
- First of the month or fifth of the month withdrawal is available.
- Checking or savings account withdrawals are allowed.
    - If checking is indicated, attach a preprinted voided check.

    - If savings account is indicated, completion of an Authorization Form M-5779, which includes the bank account numbers, is required.
- For STMM a service fee of $10.00 is added to the EFT option every month, including the initial payment.

The following premium amounts must accompany the application:

- Amount for the first full month.
- Service fee of $10.00 for the first full month.
- Amount for any odd days plus the partial service fee.
    - If using monthly payment method, the $10.00 service fee must be added to the monthly rate before calculating the daily rate. (For example, requesting an effective date of April 15, STMM premium $50 plus EFT fee $10.00 = $60 x 1.5333 = $92.00. Therefore, $92.00 is the total premium of one month plus 15 odd days.)
- Termination date for applicants choosing to pay monthly must be the first of the month, regardless of the effective date of the month.

Changes to Existing Membership

Certain policy changes to remove members are permitted ***if*** the application is completed within 31 days of an event. Applications submitted beyond 31 days of the event will not be accepted.

Eligible Events for Removing Members

- Active military service.
- Death of a plan member.
- Death of a spouse/dependent child.
- Dependent child who is not a full-time student or permanently disabled turns age 19.
- Dependent child who is a full-time student reaches the age of 23.
- Dissolution of marriage or legal separation.
- Marriage of a dependent child.

Obtaining coverage from an employer is not an event to remove members or cancel the STMM policy.

Adding Members to Existing Policy Not Allowed

Unlike provisions for other individual products, members may not be added to a Short Term Major Medical policy. Those individuals may apply for their own policies.

Marriage of a plan member is not an event to add the new spouse and/or dependent stepchildren. The new spouse and/or dependent stepchildren may apply for a separate policy.

Cancellations

Except for the death of a plan member on a single contract, Short Term Major Medical is a **non-refundable** policy.

Right to Review and Return Policy

Upon receipt of the policy and ID cards, a plan member has the right to review the policy and return it with the ID cards to Wellmark and cancel the policy as never effective.

- This right must be exercised within 10 days of the plan member's receipt of the policy and ID cards.
- A full refund of paid premium will be issued, if applicable.
- In the event the member returns the policy, the member is responsible for reimbursing Wellmark for any claims paid by Wellmark.
- Wellmark has the right to recover any claims they may have paid pursuant to the returned policy.

Direct Bill Option

The direct bill option of payment does not allow for cancellation requests. The plan member cannot request the policy be terminated prior to the expiration of the policy term chosen.

EFT Monthly Pay Option

The policy may be canceled during the policy term because the policy has not been prepaid. To stop withdrawal from the financial institution, the plan member must send a request to cancel 20 days prior to the desired termination date. This request should be sent to:

Wellmark Blue Cross and Blue Shield of Iowa
Individual Enrollment
P.O. Box 9232, Station 300
Des Moines, IA 50306-9232
Or fax 515-248-5309

If the request is received after the 20 days prior to the cancellation and the plan member does not want a draft against his/her account, he/she must notify the bank directly:

- With the exact premium amount.
- Within the financial institution's procedures.

The plan member will be responsible for any stop pay charge. Any unused premium will be refunded.

Note: It is possible the financial institution may have received a "stop payment" request from our plan member and may not allow the draft to occur.

Changes Not Allowed

- A plan member may not apply for an increase or decrease in policy benefits.
- A plan member who paid the entire premium at the time of application cannot change the length of coverage for that policy term.

Changes Allowed

- A plan member who is paying premiums through EFT can request to reduce the policy term.
    - The termination date can be no earlier than the first of the month following notification to Wellmark.

Group Conversion

Description for Marketable Products

Group conversion is a product available for Wellmark group members whose eligibility for group coverage ends due to certain circumstances, e.g., plan members that are left employees from their employer group.

- A conversion notice is generated automatically by the system when a group member is terminated for specific reasons.
    - This notice gives the left employee a time frame to notify Wellmark for conversion privileges.
    - As long as the time frames are met and the proper documents are signed and submitted, group conversion is a guaranteed issue product and health questions are not asked.
- Group conversion is considered to be a high-risk product and premiums are very expensive. Group conversion benefits do not match the employer group benefits.
- This coverage is also available to other Blue plan members who transfer to Wellmark through the Inter-Plan Transfer Program. Please refer to the "Inter-Plan Transfer Program" section for further information.

Product	**Group Conversion**		
Deductible	Plan I	Plan II	Plan III
Single	$100	$500	$1000
Two-Person/Family	$200	$1000	$2000
Coinsurance	20%	20%	20%
Annual OPM			
Single	$1000	$2500	$5000
Two-Person/Family	$2000	$5000	$10000
Lifetime Benefit Maximum for each plan is $250,000 per person covered under your policy.			

Please contact Wellmark Customer Service for additional information.

Eligibility

Eligibility for Group Conversion is available if group-sponsored coverage ends for any of the following reasons:

- Applicant's employment is terminated.
- Applicant has been laid off or is on a leave of absence.
- Applicant is no longer eligible for group coverage (e.g., a change to part-time status).
- Applicant is the widowed or divorced spouse of an employee and was covered through that person's group coverage.
- Applicant's COBRA or Iowa Extension of Coverage benefits ended.

Requirements

- Applicant must be an Iowa resident under age 65.
    - Wellmark reserves the right to require reasonable evidence that a prospective insured is a resident of Iowa.
    - Factors that may be considered include a driver's license, voter registration, and place of residence.
    - Proof of residency may include a recent property tax statement, property liability/casualty insurance statement, monthly utility statement in the proposed insured's name or a copy of a signed lease agreement.
- Applicant must apply within 31 days of termination of a Wellmark group–sponsored benefit. The conversion policy, if issued, will become effective on the day of the plan member's termination of group coverage.
- Applicant must not be eligible to be covered for similar benefits by another individual or group policy.
- Applicant must not be eligible for Medicare.

Contract Splits

Contract splits are allowed on this policy.

Forms

See Sales Toolkit.

IMPORTANT: This form must be returned no later than 9/21/2006 to:
Wellmark Blue Cross and Blue Shield of Iowa
Membership and Enrollment, Station 300
PO Box 9232
Des Moines, IA 50306-9232

AMENDED APPLICATION

I, (NAME OF PRIMARY APPLICANT OR PARENT), amend as follows my application for Wellmark Blue Cross and Blue Shield of Iowa (herein referred to as "Wellmark") health care coverage.

I consent and agree that the health care coverage contract issued by Wellmark, if any, shall not cover and will not provide benefits in connection with any treatment sought for (NAME OF CONDITION), including testing, treatment, operation or complications thereof, in the case of (NAME OF AFFECTED PERSON).

I hereby agree that this amended application shall be part of the original application and of the contracts issued, if any.

Dated this _____day of _____, 20_____.

Applicant's Signature _____
(NAME OF PRIMARY APPLICANT OR PARENT)

1 Copy Underwriting Dept.
1 Copy Applicant

ID# (TRACKING NUMBER)

CERTIFICATION OF HEALTH STATUS

Name of Policyholder:
ID Number:
Address:

Name of Member with Amendment:
Address if different:
City State:

Description of Health Coverage:
Effective Date of Coverage:

Description of Amendment:
Date of Amendment:

I hereby certify that (*** name of member with amendment) has not experienced any symptoms of and has not been affected by and has not been treated for (*** Condition name**), including but not limited to, office visits, emergency room visits, hospitalizations, medications both prescribed and over-the-counter, therapy, counseling, treatment, injections, surgery, or consultation with any health care provider relating to the condition listed above since ___/___/____ **(Date of last service or prescription for this condition)**

I certify that I am legally authorized to execute this Certification for myself and all other persons named in the Certification.

Date_____

Signature of Policyholder or Custodial Parent/Guardian_____

Print Full Name _____

I understand and agree that this Certification is in follow-up to a written request submitted by me to seek the removal of the Amendment to my Health Benefits Policy and that any such removal is subject to the approval of Wellmark, Inc. (hereinafter "Insurer"). I authorize any health care provider to release medical records to the Insurer when reasonably related to the Amendment referenced above. If any law or regulation requires additional authorization for release of medical records, I will give this authorization. I further agree upon request to furnish the Insurer with information required to review the Amendment. I further understand and agree that the information to which I am certifying on this form is accurate, and that any misstatement or misrepresentation of the information to which I am certifying on this form will permit the Insurer to reinstitute the amendment, rescind coverage, or pursue any other remedies available to the Insurer as described in my Health Benefits Policy.

Glossary

Basic and Standard: Basic and Standard plans provide comprehensive major medical coverage with benefits for fundamental health care needs. Basic and Standard plans, also referred to as state-mandated plans, are not eligible for new sales effective 1/1/05.

Benefit Period: Benefit period is the same as a calendar year. It begins the day the policy/certificate becomes effective and ends on December 31 that same year. A new benefit period begins each January 1.

COBRA: (Consolidated Omnibus Budget Reconciliation Act of 1985): Entitles ex-employees of companies with 20 or more workers to continued coverage under the group plan for 18 months after leaving.

Conversion Coverage: Coverage that may be available to a person after coverage ceases under his/her current policy/certificate.

Dependent Child: A member's natural child; a child placed with a member for adoption or a legally adopted child; a child for whom a member has legal guardianship; a stepchild; or a foster child. To receive coverage under a parent's plan, the child may have to satisfy age, residence or other eligibility requirements.

Effective Date: The date upon which contracted insurance benefits become available.

EFT: Electronic Fund Transfer is used for all automatic withdrawals.

Exclusion Period: The length of time a member may have to wait before certain medical conditions are eligible for benefits under a certificate/policy.

Family Coverage: Coverage for the plan member and eligible family members.

FTD: Failure to Disclose a medical condition that existed at the time of application.

Full-Time Student: A dependent claiming status as a full-time student. The dependent must be enrolled in an accredited institution of higher learning such as a college, university, nursing school or trade school and must be considered full-time as defined by the institution in which the dependent is enrolled. Full-time student status continues during:

- regularly scheduled school vacation periods; and
- absence from class in which enrolled for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.

Grace Period: The grace period applies to direct pay policies only and allows a plan member to pay premiums within 31 days of the due date. During this time, the policy remains in force.

HIPIOWA: Health Insurance Program of Iowa.

Identification Card: The card issued by Wellmark Blue Cross and Blue Shield of Iowa. Information on the card, especially the identification number, is required by the providers and the insurer to process claims correctly and to answer questions.

Medicaid: Form of public assistance sponsored jointly by federal and state governments providing medical assistance for eligible persons whose income falls below a certain level. The program was created by the Social Security Act of 1965.

Medicare: Federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. Medicare also provides benefits for those with chronic renal disease who require hemodialysis or kidney transplant.

Medicare Dependent Rate: Rate for spouse not eligible for Medicare and unmarried, dependent children of Medicare-eligible member who is enrolled in Wellmark Senior Blue coverage. (Available only to Pools 1 – 3.)

Medical Underwriting: Process by which the health status of individuals is evaluated to determine whether to provide coverage, under what conditions to provide coverage, and what rate to charge.

Member: The plan member, the plan member's spouse, and the plan member's dependent children eligible to receive benefits under the policy/certificate.

Plan Member: The person who signs for a policy/certificate and is eligible to receive the benefits (The policyholder).

Pre-existing Condition: Any illness or injury, or any medical, surgical or other condition (including a mental health condition, chemical dependency or pregnancy) that existed before a benefits policy/certificate became effective.

Pre-existing Condition Amendment: The provision in insurance policies which excludes benefits for health conditions that existed before the policy/certificate was effective. These amendments may be written to exclude specified conditions entirely or for a certain period of time.

Qualified Medical Child Support Order: A document that creates or recognizes the right of persons named in the order to enroll in the health benefit plan for which persons or their dependents are eligible. Medical Underwriting guidelines apply even when this order is issued.

Qualifying Previous Coverage: Benefits or coverage that has been in effect for at least one year, provides benefits similar to or exceeding those of the Standard Plan (as described in Code of Iowa Chapter 513C), and is provided under: any group health insurance; or an individual health benefit plan, including coverage issued by a health maintenance organization, a fraternal benefit society, a non-profit medical and surgical

plan, or a non-profit hospital service plan; or an organized delivery system. Medicare, Medicare Supplement, and Short Term Major Medical coverages are not qualifying previous coverage.

Rate Up: Rate up is an increase in premium at Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. (collectively Wellmark) and is given in response to specific health conditions.

Reinsurance Pool: Common fund to help insurers mitigate expected high losses from insuring high-risk individuals. A single entity, usually government-run, reimburses all medical claims. Consumers typically pay a uniform tax rather than premiums. Money goes to a single health care trust fund used only for health care expenditures.

Risk Pools: Programs created by state legislatures for people who cannot get insurance in the private market. Funding for the pool is subsidized through assessments from insurers or through government revenues.

Single Coverage: Coverage for the plan member only.

Spouse: Husband or wife as the result of a marriage that is legally recognized in the state of Iowa.

State-Mandated Benefit Laws: State laws that require insurers to cover specified health services or services from certain health care providers.

STMM: Short Term Major Medical.

Two-person Coverage: Coverage for a plan member, plus the member's spouse or dependent child.

Appendix

Change in Plan Member's/Policyholder's Name

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. (collectively Wellmark) only allows changing the name of the plan member/policyholder for tax purposes. An application must be submitted with the request.

- Documentation is required from the plan member's accountant or attorney.
- The prior plan member must continue on the plan as a covered member.
- A new identification number will be established.
- The new plan member must notify all health care providers of the change in identification number to ensure claims are filed correctly.
- Deductible and coinsurance satisfied under the prior plan will transfer over to the new plan if there is a change in identification numbers.

Odd Effective Date Factor Table

To figure the premium for an effective date other than the first of the month, take the monthly premium amount and multiply it by the factor corresponding to the effective date of coverage.

For example, if the premium is $52.64 per month and the effective date of coverage is the 10th of the month, multiply $52.64 x 1.7000. This determines the amount to pay ($36.85) for coverage from the 10th through the end of the month plus the first full month of premium totaling $89.49.

Effective Date	Factor
01	1.0000
02	.9667
03	.9333
04	.9000
05	.8667
06	.8333
07	.8000
08	.7667
09	.7333
10	.7000
11	.6667
12	.6333
13	.6000
14	.5667
15	.5333
16	.5000
17	.4667
18	.4333
19	.4000
20	.3667
21	.3333
22	.3000
23	.2667
24	.2333
25	.2000
26	.1667
27	.1333
28	.1000
29	.0667
30	.0333

First or Fifteenth of the Month Effective Date Table

Use the following guidelines when assigning a first or fifteenth of the month effective date for a new applicant.

APPLICATION SIGNATURE DATE	POLICY/CERTIFICATE EFFECTIVE DATE
January 1 through January 14	January 15 or February 1 or February 15 or March 1
January 15 through January 31	February 1 or February 15 or March 1 or March 15
February 1 through February 14	February 15 or March 1 or March 15 or April 1
February 15 through February 29	March 1 or March 15 or April 1 or April 15
March 1 through March 14	March 15 or April 1 or April 15 or May 1
March 15 through March 31	April 1 or April 15 or May 1 or May 15
April 1 through April 14	April 15 or May 1 or May 15 or June 1
April 15 through April 30	May 1 or May 15 or June 1 or June 15
May 1 through May 14	May 15 or June 1 or June 15 or July 1
May 15 through May 31	June 1 or June 15 or July 1 or July 15
June 1 through June 14	June 15 or July 1 or July 15 or August 1
June 15 through June 30	July 1 or July 15 or August 1 or August 15
July 1 through July 14	July 15 or August 1 or August 15 or September 1
July 15 through July 31	August 1 or August 15 or September 1 or September 15
August 1 through August 14	August 15 or September 1 or September 15 or October 1
August 15 through August 31	September 1 or September 15 or October 1 or October 15
September 1 through September 14	September 15 or October 1 or October 15 or November 1
September 15 through September 30	October 1 or October 15 or November 1 or November 15
October 1 through October 14	October 15 or November 1 or November 15 or December 1
October 15 through October 31	November 1 or November 15 or December 1 or December 15
November 1 through November 14	November 15 or December 1 or December 15 or January 1
November 15 through November 30	December 1 or December 15 or January 1 or January 15
December 1 through December 14	December 15 or January 1 or January 15 or February 1
December 14 through December 31	January 1 or January 15 or February 1 or February 15

Transfers Within Wellmark Products

Existing Plan Member

Wellmark requires existing plan members to meet certain criteria when transferring between Wellmark products.

Transfers Between Direct Pay & Farm Bureau Products

- Full medical underwriting will be required.
- Effective date is the first of the month following the signature date on the application.
- Agent of record changes will not b**e honored** for:
    - Secure Blue, Secure Blue Select or Blue Care options.
    - Plan members wishing to retain their current benefit level.
    - A plan member wishing to stay within the same health plan.

Transfers Into Individual Market from Employer Group

Plan members who terminated coverage with a Wellmark or subsidiary employer group are eligible to apply for continuous coverage through Wellmark's individual market. The following information must be submitted:

- An underwritten application within 31 days of cancellation from the employer group contract.

Wellmark will coordinate the effective dates for continuous coverage.

Transfers Into Wellmark Employer Group from Individual Market

Wellmark will assume individual coverage will remain active upon receipt of an employer group application. If the plan member wants to terminate the individual coverage, Wellmark **must receive, in writing, the cancellation request**.

List Bill Groups

List Bill Groups provide an alternative billing procedure to purchase individual products. This procedure allows employers to withhold 100 percent of employees' individual premiums through payroll deduction and remit those premiums directly to Wellmark.

Requirements

List Bill Group requirements include:

- Five or more members are required to establish and maintain a group.
- Employer or group sponsor must collect payments through payroll deductions.
- The employer must not contribute toward the cost of employee or member coverage in any portion or fully.
    - This rule is applicable to groups who also offer Section 125 benefits.
    - There are no exceptions to this rule.
- Dental is not an option for Direct Pay List Bill groups.

Enrollment Procedures

Applications

- All List Bill applications must have the assigned list bill group number (if known) or "List Bill" written on the top of the application. If this information is not present, Wellmark will process this application under normal application processing procedures.
- The application must indicate an effective date.
    - The signature date must be prior to the effective date.
    - The effective date must be the first of the month.
    - If the application does not have an effective date, Wellmark will assign an effective date based on approval date.
- Wellmark's Underwriting department will review the applications according to current guidelines.
    - Rejected applications will be retained by Underwriting and will be noted on the transmittal as such.
    - Each rejected applicant will receive a letter from Medical Underwriting explaining the member's options.

Required Forms

- The Premium Administrator's Agreement for Individual Payment Plan (form M-5737) must be attached to new group application(s).
- Each new List Bill applicant must complete the Authorization of Premium Payment for Individual Coverage Form (form G-5714).
    - If the administrator wishes to include an existing direct pay policyholder on the list bill, the policyholder need NOT complete a new application; he or she simply needs to complete this Authorization form.
- The agent must complete the Individual Premium Plan Application Transmittal Form (form N-5721) for each new list bill group. All applications submitted must be listed.

Contract Changes

Certain policy/certificate changes are permitted without answering health questions if the application is completed within 31 days of an event, except for adding a newborn or newly adopted child in which case the application must be submitted within 60 days. A new application must be completed when adding or deleting members due to an event. If the application is submitted beyond the event time period, health questions must be answered and the application is subject to underwriting approval. It is important to send in changes as they occur.

Certain contract changes may result in a change in the member's premium. These changes in premiums will be noted on the next bill.

Member Cancellation

Notification for cancellation of member coverage shall be submitted to Wellmark on or before the cancellation date in order to prevent payment of claims. In order to receive the most accurate and current bill, it is important that groups submit changes on a weekly basis.

If the group does not have the policyholder's signature to cancel the individual coverage, a letter will be sent to the terminated list bill member offering them the opportunity to retain the benefits and to be billed directly or through automatic account withdrawal.

Wellmark will also accept cancellation requests from the member.

Group Cancellation

If the entire group chooses to cancel, Wellmark must receive a letter from the group administrator. When this information arrives in membership, letters will be mailed to the individuals insured offering them the opportunity to continue coverage on an individual billed basis.

Group Termination

Wellmark may terminate groups for the following reasons:

- If a group contributes to the employee premium.
    - Once the list bill group has been terminated, the employer cannot take advantage of the list bill arrangement for 36 months.
- If a group has less than five members
    - Wellmark will audit all list bill groups quarterly and if the list bill group falls below five members, Wellmark will notify the group.
    - The list bill group has 90 days from notification to increase the number of participating employees.
    - If after the 90-day period the group still has less than five employees participating, Wellmark will terminate their list bill status.
    - Wellmark will continue to accept premium payments by deducting employees' premiums from the group's bank account, billing employees directly on a quarterly basis or billing the group directly on a quarterly basis.

Premium Billing

Wellmark will provide a list bill group billing statement for each billing period. This statement contains a listing of all plan members enrolled in a group at the time it is prepared. List bill groups should use this statement to verify membership and pay the necessary premium amount due.

All changes to membership must be sent as they occur. Member changes will appear in detail on the next month's bill. Also, credits or adjustments will be on the next month's bill.

List Bill premiums are due on the first of the month of the billing period. As indicated in the Premium Administrator's Agreement for Individual Payment Plan (form M-5737), the list bill administrator agrees to pay the premiums a month in advance.

Premiums may be paid via a standard check, cashier's check or money order. If the group administrator is issuing payment for more than one group, the administrator will need to submit separate checks for each group to avoid misallocation.

As with all individual health products, policies generally will rerate on January 1 of each year. A letter will be issued to each member notifying them of their new rates. The group administrator will also receive a letter summarizing the rate changes for each list bill member. This will happen automatically during the rerate process.

Premium Checklist

- All premium monthly balances will move forward.

- The group will need to pay as billed and not alter the bill.
- New members with more than one month's premium on a bill will have until the next bill due date to pay.
- To ensure that the list bill continues without interruption, the group must pay as billed. If the group has not received payment from members on the group, they must submit payment on their behalf or remove the member(s) from the list bill group.
- Payment should be mailed with the group statement to:

  Wellmark, Inc.
  PO Box 10353
  Des Moines, IA 50306

Delinquency Process

Delays in receipt of premium payments may result in the late settlements of employee's health claims. To avoid unnecessary delays, the following collection procedures are in place.

- When a premium payment for a policy is 15 days past due, Wellmark will send a payment reminder to the group.
- When a premium payment for a policy is 31 days past due, the list bill arrangement is canceled. Any unpaid premium is still due, and Wellmark reserves the right to use a collection agency when necessary.
- Once the list bill arrangement has been terminated, the employer cannot take advantage of the list bill arrangement again for 36 months.
- If the group is canceled, Wellmark will bill the employees directly on a quarterly basis. If an employee wants to cancel coverage, he or she must notify Wellmark in writing.
- If an employer does not have payment from an individual, the member will be removed from the list bill group and will be issued an individual policy. They will not be allowed to return to the list bill group for 12 months.

Agent of Record

Individual Business

Wellmark Blue Cross and Blue Shield of Iowa and Wellmark Health Plan of Iowa, Inc. (collectively Wellmark) is obligated by contractual agreement to pay new and renewal commissions to the original writing Agency as long as the Agency agreement and the policy are in force. Assignment of commission and change of Agent on any particular individual Alliance Select, Classic Blue, Secure Blue, Secure Blue Select, Blue Care, Short Term Major Medical, Senior Blue or Senior Blue Select contract can only be changed if one of the following conditions occurs:

- Fraud or gross customer abuse.
- Agent or customer misrepresentation.
- Contracted Agent becomes a Sub-Agent through segmentation classification.
- Submission of an under age 65 application (requiring answering of health questions) that results in a change of health plan (WHPI or WBCBSI), contract holder or pool of business.
- Submission of a new application for a different line of business, e.g., a member moving from an underwritten product to a Medicare Supplement or Short Term Major Medical policy.

Changing existing Senior Blue coverage to higher or lower benefits and converting Senior Blue Select coverage are considered retention activities; no production credit or Agent transfer will be granted.

Alleged “Agent of Record” letters on existing individual business will not be accepted by Wellmark when only requesting a change in Agent or Agency.