AllianceSelect℠

Benefit Summary – Groups 2-100

Copayment PPO Plan JNL

Your Alliance Select health plan allows you to receive care from any health care provider you choose but when you choose a health care provider who participates in the Alliance Select network, you reduce your out-of-pocket expenses. To find an in-network health care provider, refer to the Alliance Select health care provider directory or visit *www.wellmark.com*.

Health Plan Basics	In-Network Benefit	Out-of-Network Benefit
Benefit Period Deductible *Amount you pay in a calendar year before benefits are available.*	$2,000 Single $4,000 Family	
Coinsurance *Percentage of medical expenses you pay after the deductible is met, until you reach your out-of-pocket maximum.*	20%	30%
Office Services *Amount you pay at the time you receive certain office-based services.*	$20	30% after deductible
Emergency Care *Amount you pay for emergency room and related facility and practitioner services.*	$150	30% after deductible
Out-of-Pocket Maximum (OPM) *Maximum amount you pay for covered services each calendar year. Deductible and coinsurance apply to OPM. Once your OPM is satisfied, most services are covered in-full through the end of the calendar year.*	$4,000 Single $8,000 Family	
Lifetime Maximum *Maximum amount each covered family member is eligible to receive under this plan for covered services in his or her lifetime.*	$2,000,000	
Care Outside Iowa – BlueCard® program	Provides coverage nationwide by using providers of the Blue Cross and/or Blue Shield plan in the area where you receive services. You must use an in-network provider to receive the highest benefit level.	

Covered Benefits *When you receive these services, you pay:*	In-Network Benefit	Out-of-Network Benefit
Preventive Care • Routine physical exam (includes gynecological exam) • Immunizations • X-ray/lab • Mammogram • Pap Smears • Prostate screening • Well-child care to age 7 (deductible waived)	$20 copayment	30% coinsurance after deductible
Ambulance	20% coinsurance after deductible	30% coinsurance after deductible
Chiropractic Care	$20 copayment	30% coinsurance after deductible
Contraceptives Injected and implanted contraceptives, and contraceptive devices. (Oral contraceptives are covered under Blue Rx℠ Preferred prescription drug program.)		30% coinsurance after deductible
Office services	$20 copayment	
Facility services	20% coinsurance after deductible	
Emergency Room • Facility services • Physician services	$150 copayment	30% coinsurance after deductible Medical emergencies and accidents covered at in-network benefit level.

Covered Benefits (continued) *When you receive these services, you pay:*	***In-Network Benefit***	***Out-of-Network Benefit***
Facility Services • Inpatient hospital • Outpatient hospital • Nursing facility	20% coinsurance after deductible	30% coinsurance after deductible
Home/Durable Medical Equipment	20% coinsurance after deductible	30% coinsurance after deductible
Home Health Care	20% coinsurance after deductible	30% coinsurance after deductible
Hospice Services	20% coinsurance after deductible	30% coinsurance after deductible
Independent Lab Services	$20 copayment	30% coinsurance after deductible
Maternity Care • Physician services • Facility services	20% coinsurance after deductible	30% coinsurance after deductible
Mental Health/Chemical Dependency Office visit Inpatient/Outpatient hospital	 $20 copayment 20% coinsurance after deductible	30% coinsurance after deductible
Office Services • Physician services, X-rays, labs, etc.	$20 copayment	30% coinsurance after deductible
Physician Services • Inpatient facility care • Outpatient facility care	20% coinsurance after deductible	30% coinsurance after deductible
Prescription Drugs	Covered under Blue Rx℠ Preferred prescription drug program. Refer to your drug plan benefit summary for cost information.	

Limitations/Exclusions

The following list identifies services Wellmark Blue Cross and Blue Shield typically limits or does not cover under this health plan. For specific benefit information, visit Wellmark's *View Eligibility & Benefits* file in the Member section of *www.wellmark.com*, or call the Customer Service number on your ID card.

Copayments (Office Visits/ER) – Copayments do not apply to the out-of-pocket maximum, and are taken once per office practitioner or ER facility per date of service.

Dental Treatment – For accidental injury only, if initiated within 72 hours and completed within 30 days.

Hearing/Vision Exams – Not covered.

Hospice Respite – Lifetime maximum is limited to 15 days inpatient/15 days outpatient.

Infertility – Limited to diagnosis only.

Mammograms – One per benefit period.

Mental Health and Chemical Dependency Treatment – Inpatient hospital is limited to 30 days per benefit period; office visits/outpatient hospital is limited to 52 visits per benefit period.

Miscellaneous – Not covered.

- Cost of Blood
- Hearing Aids
- Smoking cessation exams/drugs/items

Nursing Facility Care – Limited to 90 days per benefit period.

Physicals – Limited to one per member per benefit period.

For more information about your benefits, go to *View Eligibility & Benefits* file in the Member section of *www.wellmark.com* or call Customer Service.

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the benefits certificate or coverage manual you will receive after you enroll and the enrollment regulations in force when the certificate or manual becomes effective. Certain exclusions and limitations apply.

10/06

Benefit Summary

Blue RX Preferred - Prescription Drug Plan
T97

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the benefits certificate or coverage manual you will receive after you enroll and the enrollment regulations in force when the certificate or manual becomes effective. Certain exclusions and limitations apply.

With the Blue Rx Preferred three-tier plan, the amount you pay for your prescriptions depends on whether the drug is generic or brand, and the type of brand name drug.

Annual Deductible	Tier 1 Generic Drugs	Tier 2 Specially Selected Brand-Name Drugs	Tier 3 All Other Brand-Name Drugs
$0	$8	$35	$50

Visit the Pharmacy section at www.wellmark.com for further information.

If you purchase a Tier 2 or Tier 3 drug when an A-rated generic drug is available, you are responsible for your copayment amount plus any difference in price between the billed charge for the generic drug and the billed charge for the brand-name drug. You are responsible for this difference even if your provider has specified that you must take the brand-name drug.

If the pharmacy's charge is less than the copayment amount, you pay only the pharmacy charge.

All drugs must be self-administered according to the instructions given by the practitioner and the pharmacist.

Drug Quantities

- Mail order maintenance prescriptions: 90-day supply for two copayments
- Maintenance prescriptions purchased at a participating network pharmacy: 90-day supply for three copayments
- All other prescriptions: 30-day supply for one copayment.

Benefit Summary
Blue RX Preferred Prescription Drug Plan

Covered Services

- Most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription."
- Drugs dispensed by a pharmacist from a licensed retail pharmacy.
- Prescription drugs that are prescribed by a practitioner legally authorized to prescribe.
- Insulin and these insulin supplies: needles, syringes, test strips, and lancets.
- Prescription contraceptives and contraceptive devices

Non-Covered Drugs and Services

- Cosmetic drugs
- Drugs administered by injections, except insulin, injectable drugs for the treatment of migraine headaches, and EpiPen.
- Drugs determined to be abused or otherwise misused by you
- Drugs that require a prescription by state law but not federal law
- Growth hormones
- Immunization agents
- Infertility drugs
- Investigational drugs
- Irrigation solutions and supplies
- Nutritional supplements
- Over-the-counter products including nutritional dietary supplements
- Self-help or self-cure programs
- Therapeutic devices or medical appliances
- Weight reduction drugs
- Prenatal vitamins
- Smoking cessation

Benefit Summary

Blue Dental
Plan 207

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the benefits certificate or coverage manual you will receive after you enroll and the enrollment regulations in force when the certificate or manual becomes effective. Certain exclusions and limitations apply.

Dental Plan Basics	
Benefit Period Deductible - The fixed amount you pay for covered services before Wellmark makes a benefit payment.	$25 per covered person per calendar year Maximum of 3 deductibles per family per calendar year No deductible for diagnostic and preventive care
Benefit Period Maximum - The maximum amount each covered family member is eligible to receive under this plan for covered services in one benefit period.	$2,000

When You Receive These Covered Services:	You Pay:
Diagnostics and Preventive Care • Dental cleaning/prophylaxis—twice per benefit period • Oral evaluations - twice per benefit period • Topical fluoride applications—for dependent children under the age of 19 once every 12 consecutive months • X-rays * Bitewing x-rays—once every 12 consecutive months * Full-mouth x-rays—once every 5 consecutive years * Occlusal and extraoral x-rays * Periapical x-rays • Topical sealant applications—for eligible dependent children under age 15; once per permanent first and second molars in a lifetime • Space maintainers—only for dependent children under age 15 • Periodontal maintenance therapy	$0 Covered in full Deductible does not apply

When You Receive These Covered Services:	You Pay:
Routine and Restorative Care • Contour of bone (alveoloplasty) • Emergency treatment for the relief of pain or infection of dental origin • General anesthesia/sedation • Restoring decayed or fractured teeth • Limited occlusal adjustment • Routine oral surgery	20% coinsurance after deductible
Root Canals • Apicoectomy/periradicular surgery • Direct pulp caps • Pulpotomy • Retrograde fillings • Root canal therapy	50% coinsurance after deductible
Gum and Bone Diseases • Conservative periodontal procedures (periodontal splinting, root planing and scaling)—once every 24 consecutive months for each quadrant • Complex periodontal procedures—once every 3 consecutive years for each quadrant	50% coinsurance after deductible
High-cost Restorations • Cast restorations for advanced tooth decay or fracture—once every 5 consecutive years beginning from the date the cast restoration is cemented in place * Crowns—limited to teeth that cannot be restored with a routine filling and once every 5 years per tooth * Onlays * Inlays * Posts and cores	50% coinsurance after deductible
Dentures and Bridges • Bridges once every 5 years • Bridge repair • Dentures—once every 5 consecutive years • Denture relining if performed 6 months or more after initial placement and limited to once every 2 years • Implants	50% coinsurance after deductible

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

BlueDental

FORT DEARBORN LIFE
Insurance Company

Failure to fill out this application completely may result in a delay of coverage.

Group Application For Health, Dental & Life Insurance

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee ☐ Change

This area completed by Employer: Group/Billing Unit No.__________ Department No. ______ Effective Date______

Employer Name: __________ Employer Address: __________

A. Employee Information

Name (First, Last): __________ Soc. Sec. Disabled? ☐ Yes ☐ No Medicare Enrolled? ☐ Yes ☐ No

Address: __________ ☐ Male ☐ Female Birthdate: __________

City, State, Zip: __________ Marital Status: ☐ Single ☐ Married ☐ Common Law

Telephone: (____) __________ Social Security Number:__________

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA Hire Date: __________

B. Members Covered (Please indicate who you are choosing to cover.)

Health: ☐ Self ☐ Spouse ☐ Child(ren) **Dental:** ☐ Self ☐ Spouse ☐ Child(ren) **Health Coverage Selected:**__________ **HSA:** ☐ Yes ☐ No

Life: * ☐ Self ☐ Spouse ☐ Child(ren) **Disability:*** ☐ Employee/Short-Term ☐ Employee/Long-Term

List Name (First, Last) of all others to be covered	Birthdate	Social Security Number	Gender	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes	☐ Yes ☐ No	☐ Yes ☐ No

C. Event(s) or Reason(s) for Changing Contract

☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Change of Spouse's Employment ☐ Other, Specify: __________ Date of Event: __________

D. Medicare Coverage

Name of person covered by Medicare: __________ Effective Date (Part A): __________

Medicare ID (HIC) No.: __________ Effective Date (Part B): __________

E. Other Carrier Information

☐ Yes ☐ No Will you, your spouse or your dependents keep other health coverage in addition to this Wellmark, Inc. coverage?
If yes, please complete the following section. Policy No.: __________

Name (First, Last): __________ Who is covered by the other health plan?

Employer (if applicable): __________ ☐ Self ☐ Spouse ☐ Children

Insurance Company/HMO Name and Address:__________ Effective Date: __________

F. Prior Coverage Information

☐ Yes ☐ No New Hire: Did you, your spouse or dependents have health coverage within 63 days prior to the hire date stated above?
☐ Yes ☐ No Special Enrollee/Late Enrollee: Did you, your spouse or dependents have health coverage within 63 days prior to the effective date of this coverage? If yes, please complete the following:

Name of Ins. Co.: __________ Policy No.: __________
Covered Person(s): __________ Effective Date: __________ End Date:__________

G. Life/Disability Options (Please complete only if you checked life or disability above.)	Date of Birth	Social Security #	Relationship	Benefit %
☐ Primary Beneficiary				
☐ Primary Beneficiary ☐ Contingent Beneficiary (Please indicate if beneficiary is Primary or Contingent)				

Employee Salary: ☐ Weekly ☐ Monthly ☐ Annual $ __________ Occupation: __________ Insurance Class: __________

*(Underwritten by Fort Dearborn Life Insurance Company.)

H. Waiver of Enrollment (Please complete if you are waiving health, dental or life benefits.)

☐ I waive health coverage for my dependents and myself. Please indicate one of the following reasons:
☐ I (We) have coverage under another health care benefit plan. ☐ I (We) do not wish to enroll in the health plan.
☐ I waive dental coverage for my dependents and myself. Please indicate one of the following reasons:
☐ I (We) have coverage under another dental plan. ☐ I (We) do not wish to enroll in the dental plan.

☐ I waive life coverage.
☐ I waive disability coverage.

Note: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself or your dependent in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage. However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact Customer Service, Wellmark, Inc., P.O. Box 9232, Station 9, Des Moines, IA 50306-9232.

I. Authorization and Certification

I have read and understand the Authorization and Certification language on the back of this application and acknowledge receipt of a fully completed copy of this application.

Employee Signature__________ Date______/______/______

N-5411 1/05

White – Wellmark, Inc. Yellow – Employer Pink – Member/Enrollee

Authorization and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am making application for the coverage sponsored by my employer or group sponsor offered by Wellmark, Inc., doing business as Wellmark Blue Cross Blue Shield of Iowa, or Wellmark Health Plan of Iowa, Inc. (each referenced herein as "Wellmark") and, when applicable, life and/or disability insurance provided by Fort Dearborn Life Insurance Company (collectively the "Plans"). I authorize my employer, as my agent, to deduct from my pay or collect from me in advance the monthly rates therefore and remit such sums to the Plans on my behalf. This authorization is to remain in effect until the Plans are notified by me or my employer to the contrary. I understand that written notice of rate changes will be furnished by my employer as my agent. I further understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by each Plan and an effective date of coverage is established by the Plans.

I certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Plans will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Plans will be entitled to declare the contracts applied for void and to refuse allowance on benefits to any person thereunder.

In the event I have selected Health Savings Account (HSA) coverage on this application, I understand that enrolling in HSA coverage does not guarantee that I am or will be eligible to make contributions to an HSA or that contributions can be made to an HSA on my behalf.

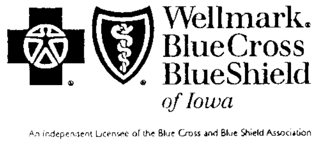
If I am applying for life and/or disability insurance, I understand that if I am not actively at work on the effective date of my coverage, my life and/or disability insurance will not begin until the day I return to work. I further understand that if I have chosen to waive life and/or disability insurance and I wish to reapply at a later date, I will be required to furnish evidence of insurability satisfactory to the life insurance carrier selected by my employer or group sponsor.

I authorize any health care provider, including but not limited to; surgeon, physician, psychologist, nurse, social worker, or health care facility to release to the Plans all health & mental records, including those records protected by Federal or State law relating to AIDS or AIDS related complex, mental health and substance abuse, the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage. This information is being used to carry out pre-enrollment underwriting and is in force until that process is complete, at which time it expires. I understand that I have the right to revoke this authorization in writing at any time by delivering such written notification to the requestor. I understand that a revocation is not effective until received by the requestor. I further understand that any revocation is not effective to the extent that the Plans or Provider have relied on it in the use or disclosure of protected health information.

This form does not authorize the redisclosure of medical information. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. Wellmark maintains the confidentiality of **all** information received and it will not be released to any person or facility unless the individual is applying for life and/or disability coverage underwritten by Fort Dearborn Life Insurance Company in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to Fort Dearborn Life Insurance Company.

The protected health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

I understand that I have the right to refuse to sign this authorization, but that the Plans then have the right to condition eligibility determination and enrollment on the receipt of this signed authorization.



#5 General Notice of Preexisting Condition Exclusion (Iowa-12, 18, 6 months)

The Health Insurance Portability and Accountability Act (HIPAA) regulations require we provide you with the following information specific to your employer's health plan. It is important that you read and understand the information contained in this section. After reviewing this material, additional questions should be directed to either Wellmark's customer service department or your employer group health plan sponsor. You can reach customer service toll-free by calling: 800-355-2031.

You can also find this information in your benefits certificate which you will receive after you enroll.

Preexisting Condition Exclusion Period		Look Back Period
New Hires & Special Enrollees	Late Enrollees	
12 Months	18 Months	6 Months

*NOTE: If you are a participant in a brand new group to Wellmark (size 2-50 employees) and your group has not provided group sponsored coverage for the past 3 months, a standard pre-existing condition exclusion period of 6 months applies for all participants at initial enrollment. Please see your group administrator to determine if this applies to you as a participant.

What is a Preexisting Condition Exclusion?

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to the plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. Preexisting condition exclusions apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the *Look Back Period*. The preexisting condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

What is the Look Back Period?

The look back period is the period of time, as shown above, that ends on the day before the effective date of your coverage under our plan; or, if you have a waiting period before your coverage under our plan is effective, the period of time, as shown above, that ends on the day before the first date of the waiting period.

When Does a Preexisting Condition Exclusion Period Begin?

This preexisting condition exclusion period begins on the effective date of your coverage; or, if you have a waiting period before your coverage under our plan is effective, the exclusion period begins on the first date of the waiting period.

How does Prior Creditable Coverage Impact Preexisting Condition Exclusion Periods?

You can reduce the length of the preexisting condition exclusion period by the number of days of your prior creditable coverage. Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion period if you have not experienced a break in coverage of at least 63 days. To reduce the exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.