

BluePrioritySM HSA

BLUE SELECT HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLANS OUTLINE OF COVERAGE

HEALTH PLANS *for Individuals & Families*

HEALTH PLANS *for Individuals & Families*

YOU SHOULD READ YOUR POLICY CAREFULLY.

THIS OUTLINE OF COVERAGE FOR BLUE PRIORITY HSA-QUALIFIED BLUE SELECT HIGH DEDUCTIBLE HEALTH PLANS PROVIDES A BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR POLICY.

This is not your policy. Only the actual benefit provisions in your policy will determine your benefits. The policy itself sets forth in detail the rights and obligations of both you and Wellmark Blue Cross and Blue Shield of South Dakota.

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

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

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

This coverage is available to you ("single" coverage) or to you and your family ("family" coverage, including your spouse and/or unmarried dependent children). You will pay the premium for coverage directly to Wellmark.

DEDUCTIBLE

The deductible is the fixed dollar amount you pay for covered services before benefits are available. There are individual and family deductibles.

FAMILY DEDUCTIBLE

The family deductible can be met through any family member or combination of family members. The entire deductible amount must be met before benefits are payable from the BluePriority HSA-qualified high deductible health plan.

COINSURANCE

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

Coinsurance is based on:

- The payment arrangement amount minus deductible and contract limitations for all covered services provided by providers in South Dakota and Iowa.
- The local Blue Cross and Blue Shield Plan's payment arrangement amount minus deductible and contract limitations for covered services received outside of South Dakota or Iowa.

OUT-OF-POCKET MAXIMUM (OPM)

The maximum amount you pay for covered services in a benefit period is called out-of-pocket maximum. Your out-of-pocket maximum for in-network services equals the deductible. Your out-of-pocket maximum increases if you receive services from a provider who does not accept our payment arrangement amount (a "non-participating" or "out-of-network" provider), or if you receive services that are subject to limitations.

LIFETIME BENEFIT MAXIMUM

In a covered person's lifetime, total benefits accumulated under this policy and any other individual policy issued by Wellmark are limited to \$2,000,000.

PROVIDER PAYMENT ARRANGEMENTS

We use various methods to determine payment arrangements, including negotiated fees, based upon our contracting

relationships with providers. These payment arrangements usually result in provider savings and can affect how your coinsurance is calculated.

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

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

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

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

BLUE SELECT PROVIDER NETWORK

Blue Select is a preferred provider organization or PPO, a unique network of contracted providers that offers financial incentives to seek care from those providers. Your Blue Priority HSA-qualified high deductible health plan uses the Blue Select provider network. Some key features of Blue Select:

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

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

HEALTH SAVINGS ACCOUNTS

Blue Priority HSA-qualified high deductible health plans work in combination with a health savings account (HSA) to help you save and pay for your health care.

Enrolling in a Blue Select HSA-qualified high deductible health plan is compatible with an HSA that will allow you to pay for qualified medical expenses such as office visits, prescription drugs, dental expenses, and laboratory tests. Contributions to an HSA are tax deductible and can earn tax-free interest.* You decide how and when to use your HSA funds. For example, you may use your HSA to pay for your health care until you meet your health plan deductible or you

may save the funds to pay for future medical expenses. Unlike other reimbursement-type plans, money in an HSA can accumulate indefinitely. After age 65, HSA funds can be used for other purposes, not just medical expenses, without incurring any penalties.**

Many financial institutions, including banks and credit unions, offer HSAs. Wellmark works with an HSA administrator, First Horizon Msaver, to make it easy for you to open an HSA. The First Horizon Msaver HSA features no set-up fees, convenient access to HSA funds via a free debit card or free checks, and free online bill payment and banking.

*State tax treatment may vary.

**Even at age 65 or older, HSA distributions for non-medical expenses are subject to income tax.

BluePrioritySM HSA-Qualified High Deductible Health Plans

PLAN COMPARISON CHART

The deductible amount may change each year in accordance with the federal government's cost-of-living adjustments for high deductible health plans that qualify to accompany a BluePriority Health Savings Account. This adjustment will be made whether or not you participate in a BluePriority HSA. **The BluePriority HSA-qualified high deductible plans featured in this outline of coverage have varying benefits. You may select one of the plans below:**

Plan Name	HSA A		HSA B	
Type of Plan	PPO		PPO	
Benefit Period Medical Deductible *	\$1,550 Single	\$3,100 Family	\$2,550 Single	\$5,100 Family
Coinsurance	0% In Network	40% Out-of-Network	0% In Network	40% Out-of-Network
Out-of-Pocket Maximum (OPM)				
Select Provider	\$1,550 Single	\$3,100 Family	\$2,550 Single	\$5,100 Family
Non-Select Provider	\$3,550 Single	\$7,100 Family	\$4,550 Single	\$9,100 Family
Lifetime Benefit Maximum	\$2,000,000		\$2,000,000	
Pre-existing Waiting Period	11 months		11 months	
Office Visit				
Select Provider	Deductible applies		Deductible applies	
Non-Select Provider	Deductible and coinsurance apply		Deductible and coinsurance apply	
Emergency Room	Deductible and coinsurance apply		Deductible and coinsurance apply	
Prescription Drugs	Covered under health. Subject to deductible and coinsurance. Coinsurance is that for Select providers.		Covered under health. Subject to deductible and coinsurance. Coinsurance is that for Select providers.	
Preventive Care	Covered — Limited to \$500 annually		Covered — Limited to \$500 annually	
Maternity	Complications only		Complications only	
Infertility	Not covered		Not covered	
Mental Health	Covered		Covered	
Chemical Dependency	Inpatient 30 days per 6 months for alcoholism only; 90 days inpatient per lifetime Outpatient care for alcoholism not covered		Inpatient 30 days per 6 months for alcoholism only; 90 days inpatient per lifetime Outpatient care for alcoholism not covered	

* The entire deductible must be met before benefits -- other than preventive care -- are payable from your Blue Select health plan. For a family plan, the entire family deductible must be met before benefits are payable for any family member.

Benefits

APPROVED HOSPITAL/HEALTH CARE FACILITY SERVICES

The BluePriority HSA-qualified high deductible health plan provides coverage for medically necessary services and supplies related to the treatment of an illness or injury when care is received as an inpatient in a facility. Approved health care facilities include ambulatory surgical facilities, community mental health centers, facilities for treatment of chemical dependency, hospitals, and nursing facilities.

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

FACILITY SERVICES

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

- Accidental injury services
- Anesthetics and their administration
- Anesthesia and hospital charges for dental care, whether services are provided in a hospital or a dental office, but only for a member who:
 - 1) is under age 14; or
 - 2) is severely disabled or otherwise suffers from a developmental disability as determined by a licensed physician which places such person at serious risk.
- Blood administration
- Chemotherapy services
- Complications of pregnancy
- Corneal grafts
- Dietary services—but only as an inpatient or when prescribed by a physician for treatment of Phenylketonuria (PKU)
- Dressings and casts
- Drugs and biologicals
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical emergency care
- Medical and surgical supplies
- Mental health and chemical dependency, with certain limitations
- Occupational therapy—limited to treatment of the upper extremities
- Physical therapy
- Rooms—including general nursing care and meals as an inpatient, or meals when prescribed by a physician for the treatment of Phenylketonuria (PKU)
- Special care units including burn care units, cardiac care units, delivery rooms, intensive care units, isolation rooms, operating rooms, and recovery rooms
- Speech therapy—limited to restoration of loss due to illness or injury and services provided inside a facility or coordinated through home health services.

APPROVED PRACTITIONER SERVICES

Some approved practitioners include:

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

- Accidental injury services
- Anesthetics and their administration
- Assisting surgeon services
- Chemotherapy services
- Concurrent care
- Consultation services
- Corneal grafts
- Dental treatment for accidental injury
- Diagnostic screening for prostate cancer including:
 - 1) An annual medically recognized diagnostic examination, including a digital rectal examination and a prostate-specific antigen test, for:
 - a. Asymptomatic men age 50 and over; and
 - b. Men age 45 and over at high risk for prostate cancer; and
 - 2) Males of any age who have a prior history of prostate cancer, medically indicated diagnostic testing at intervals recommended by a physician, including the digital rectal exam, prostate-specific antigen test, and bone scan.
- Genetic testing and counseling in certain circumstances
- Hemodialysis services
- Complications of pregnancy
- Medical emergency care
- Medical services (other than surgical or obstetrical) provided by your practitioner while you are an inpatient or an outpatient, including home and office calls
- Mental health and chemical dependency services, with certain limitations
- Occupational therapy for upper extremities

continued next page

- Physical therapy
- Preventive care limited to \$500 annually
- Radiation therapy
- Routine medical care of a newborn
- Mammography x-ray, routine:
 - for women 35-39 years of age: one baseline mammogram;
 - for women 40-49 years of age: one mammogram every two years;
 - for women 50 years of age and older: one mammogram every year.

For this benefit, a year is 12 consecutive months.

Mammograms may be more frequent if recommended by your physician.

- Surgical services
- X-ray and laboratory services

OTHER COVERED SERVICES

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

- Ambulance
- Certified diabetes education program (including insulin, insulin supplies, insulin syringes, and glucose strips)
- Home infusion therapy
- Home medical equipment — rental or purchase as determined by Wellmark
- Home skilled nursing, if given by a registered nurse (RN) or licensed practical nurse (LPN) from an agency accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager.
- Oxygen and equipment needed to administer oxygen
- Prescription drugs and medicines
- Prosthetic appliances

HOME HEALTH SERVICES

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

- Home health aide services
- Home skilled nursing, as described in “Other Covered Services” section.
- Inhalation therapy
- Medical equipment and supplies

- Medical social services
- Occupational therapy to treat the upper extremities
- Physical therapy
- Speech therapy, limited to restoration of loss due to illness or injury and services provided inside a facility or coordinated through home health services.
- Oxygen and equipment
- Parenteral and enteral nutrition
- Most prescription drugs and medicines
- Prosthetic appliances and braces

HOSPICE SERVICES

Coverage is provided to terminally ill patients with a life expectancy of six months or less. Covered hospice services include the same services as described under home health services as well as respite care from a facility approved by Medicare or JCAHO. Respite care offers rest and relief help for the family caring for a terminally ill patient.

BLUEPRINTS FOR HEALTH® DISEASE MANAGEMENT PROGRAMS

With our BluePrints for Health Disease Management Program, you receive the support you need when dealing with a chronic condition. If you're diagnosed with diabetes, cardiac condition (heart failure, coronary artery disease), asthma, or chronic obstructive pulmonary disease (COPD), you'll be invited to participate in the program.

You'll receive a welcome kit followed by a confidential welcome call from a BluePrints for Health nurse. You decide if you want to participate and what level of support you'd like to receive. In addition to the one-on-one support you receive from your BluePrints for Health nurse, you can have access to other health professionals like registered dietitians and respiratory therapists.

Our BluePrints for Health team keeps your doctor informed of your progress in the program. The goal is to support and reinforce the treatment program you and your doctor have established. Working together, we can help you and your doctor manage your disease.

The BluePrints for Health Disease Management Program is available for those who are serious about managing their chronic health conditions.

Limitations

YOUR BLUE PRIORITY HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN COVERAGE IS LIMITED AS FOLLOWS:

PRE-EXISTING CONDITION WAITING PERIOD

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

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

CHEMICAL DEPENDENCY TREATMENT

Coverage for chemical dependency treatment is limited to:

- **30 days** for the inpatient treatment of alcoholism in each six month period; and **90 days** lifetime.
- Outpatient treatment for alcoholism is not covered

COSMETIC SURGERY

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

BREAST RECONSTRUCTION AFTER MASTECTOMY

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

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of the mastectomy.

WEIGHT REDUCTION SURGERY

You must be at least 18 years of age and an appropriate surgical candidate under the following requirements to receive benefits:

- You have a Body Mass Index of:
 - at least 40 for at least three years, or
 - at least 50 (classified as super-obese), or
 - greater than 35 in conjunction with documented treatment of a coexisting medical condition of at least one of the following:
 - hypertension requiring medication for at least one year,
 - type 2 diabetes requiring medication for at least one year,
 - obstructive sleep apnea, confirmed by a sleep study, which does not respond to conservative treatment,
 - cardiovascular disease, or
 - pulmonary hypertension of obesity.
- You have a documented history of failure to sustain weight loss with medically supervised dietary and conservative treatment for at least three years, including within two years before surgery.
- You are an acceptable operative risk.

- You have been evaluated by a licensed mental health provider who documents that you are motivated to follow all necessary pre- and post-operative treatment plans.

ORGAN TRANSPLANTS

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

- Services for transportation in an ambulance to a transplant center are limited to a \$10,000 maximum per transplant.

RESPIRE CARE

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

Become familiar with your policy's limitations and exclusions.

Exclusions

The following services are excluded or are not considered medically necessary by Wellmark and will not be covered:

MENTAL HEALTH AND CHEMICAL DEPENDENCY TREATMENT

- Bereavement counseling or services
- Certain development and learning disorders
- Certain disorders of early childhood, such as academic underachievement disorder
- Chemical dependency treatment other than inpatient treatment for alcoholism
- Communication disorders, such as stuttering and stammering
- Impulse control disorders, such as pathological gambling
- Marriage and family counseling
- Nicotine dependence
- Residential treatment of mental health conditions or chemical dependency except those services received in a Residential Treatment Facility as described in your benefits policy
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders, including sex change surgery

FERTILITY AND INFERTILITY

- Collection of donor semen, oocytes, or the services of a surrogate parent
- Contraceptives
- Infertility treatment
- Maternity, except for complications of pregnancy
- Sterilization
- Sterilization reversal
- Subcutaneous implants
- Treatment of impotence unless it is the result of a physical illness or injury

MISCELLANEOUS

- Anesthesia, local or topical when not billed with a surgical procedure, except anesthesia related to the provision of certain dental services as specified and limited in the policy
- Arch supports
- Blood, purchase of
- Complications of a non-covered procedure

This exclusion does not apply to the treatment of complications resulting from smallpox vaccinations when payment for such treatment is not available through Workers' Compensation or government-sponsored programs.

- Dental services except as specified and limited in the policy
- Elastic stockings and bandages
- Hearing aids and exams
- Investigational and experimental treatment as outlined in the benefits policy
- Maxillary and mandibular implants
- Motor vehicles
- Nonmedical services
- Personal convenience items
- Speech therapy
 - 1) When services are provided outside of a facility or are not coordinated through home health services; or
 - 2) For treatment of certain developmental, learning, or communication disorders, such as stuttering or stammering.
- Services furnished to you prior to the effective date of the policy
- Travel or lodging costs
- Vision care
- Wigs

PROVIDER TYPES

- Certified registered nurses (other than an anesthetist)
- Provider is an immediate family member (exclusion does not apply in those areas in which the immediate family member is the only provider

within a 30-mile radius of the provider's main office)

- Social workers, except as described in your benefits policy

PREVENTIVE AND ROUTINE CARE

- Routine foot care
- Preventive care in excess of \$500 annually

COVERED BY OTHER PROGRAMS OR LAWS

- Services or supplies when someone else has the legal obligation to pay for your care
- Military-related illness or injury
- Services or supplies that are paid under Workers' Compensation, including any services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

THERAPY, SELF-MOTIVATION, AND OTHER PROGRAMS

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

TRANSPLANTS

- Expenses for the purchase of any organ
- Mechanical or non-human organs
- Transplant services or supplies other than heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, or bone marrow/stem cell transfers
- Transportation of a living organ donor

Notification Requirements

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

PRECERTIFICATION

The purpose of precertification is to determine whether a service or admission discussed below meets the medical necessity criteria of your benefits policy. If you choose to have these services performed even though we were unable to certify the medical necessity of the services, you will be responsible for the charges.

Precertification is required for:

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

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

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

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

You may appeal a decision to deny precertification or a benefit reduction.

PRIOR APPROVAL

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

(Even if you receive prior approval for a service, inpatient admissions may be subject to inpatient admission notification.)

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

CONCURRENT REVIEW

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

If it is determined your current level of care is no longer medically necessary, we will notify you, your attending physician and the facility 24 hours before your benefits for services end.

Please note: We will notify you of the date when coverage for services ends. We will not provide benefits for services received after this date.

CASE MANAGEMENT

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

APPEAL PROCESS

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

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

BlueCard[®]

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

WHEN YOU USE A BLUECARD PPO PROVIDER:

- Covered services you receive in the office are subject to a deductible. You pay the applicable coinsurance amount.

**Blue Cross and Blue Shield Association, 2006.*

- You'll get Blue Plan PPO-provider negotiated prices.
- Your claims will be processed at the Blue Select in-network coinsurance level.
- Participating providers have agreed not to collect from you any difference between their billed charge and the negotiated charge.
- More than 6,000 hospitals and 635,000 providers throughout the United States participate in BlueCard.*
- Participating providers and many non-participating providers will honor your ID card and file your claims for you.
- BlueCard providers do not handle notification requirements for you.

Prescription Drug Coverage

Prescription drug benefits for Blue Select plans are provided as part of the health coverage, so they are subject to plan deductible.

Catalyst Rx,[®] Wellmark's contracted pharmacy benefit manager, contracts with more than 55,000 pharmacies nationwide.* If you choose to get a prescription from a pharmacy that does not contract with Catalyst Rx, you will need to submit a paper claim to Catalyst Rx in order to receive reimbursement, and you will be responsible for any difference between the maximum allowable fee and the pharmacy's billed charge plus any deductible amount.

WELLMARK DRUG LIST

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

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

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

**Catalyst Rx, 2nd Quarter 2006.*

REBATES

Using the Wellmark Drug List helps manage the overall cost of prescription medications by promoting the use of more cost-effective drugs. Drug manufacturers sometimes offer rebates to pharmacy benefit managers based on the inclusion of their drugs on the drug list and associated utilization. We expect to receive rebates from our contracted pharmacy benefit manager. The rebates we receive as a result of your prescription claims processed by our pharmacy benefit manager will be retained by Wellmark and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific claims, and they will not be considered when determining your benefit-period deductible, coinsurance amount, or out-of-pocket maximum.

PRIOR AUTHORIZATION

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

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

General Provisions

Eligibility: You are eligible to apply for Blue Priority HSA-qualified high deductible health plan coverage if you are a resident of South Dakota, under 65 years of age, and not eligible for Medicare.

COVERAGE RENEWABILITY

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

MEDICARE ELIGIBILITY

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

MEDICARE ENROLLMENT

If you become enrolled in Medicare during the term of this policy, this policy will provide benefits primary to Medicare.

SUBROGATION

Once you receive benefits under this policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to that illness or injury. We will assume all rights for recovery, to the extent of our payment, regardless of whether our payment is made before or after settlement of any third-party claim, and regardless of whether you have received full or complete compensation for any injury or illness.

You and your covered family member(s) agree to notify us if you have the potential right to receive payment from someone else and to cooperate with us to ensure that our rights to subrogation are protected.

We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

COORDINATION OF BENEFITS

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

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

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

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

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

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

OTHER INFORMATION

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

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

WORKING WITH YOU, FOR YOU

It is important that you understand your Blue Priority HSA-qualified high deductible health plan coverage to use your benefits properly:

- Present your Wellmark identification card each time you receive health care services.
- Comply with the notification requirements described on page 9.
- Read your policy for complete details.

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



You Just Can't Beat The Blues®

1601 W. Madison Street
Sioux Falls, South Dakota 57104

Wellmark Blue Cross and Blue Shield of South Dakota is an Independent Licensee of the Blue Cross and Blue Shield Association.

www.wellmark.com

Blue Cross®, and Blue Shield®, the Cross and Shield symbols, You Just Can't Beat the Blues®, Blue Card®, Blue Prints for Health®, Blue Select®, and Senior Blue® are registered marks and BluePrioritySM and Blue RxSM are service marks of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Wellmark® is a registered mark of Wellmark, Inc.