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Amendment to Your Coverage Manual or Summary Plan Description

This amendment to your coverage manual or summary plan description (SPD) is effective **January 1, 2016**. The headings refer to sections in the coverage manual or SPD. Please review this amendment and keep it with your coverage manual or SPD.

What You Pay

Payment Summary

Out-of-Pocket Maximum.

Your out-of-pocket maximums are changing:

Blue Rx

Category	You Pay
Out-of-Pocket Maximum	$3,000 per person $6,000 (maximum) per family*

Medical

Details – Covered and Not Covered

Alcoholism Treatment

T*he following is revised:*

For treatment in a residential treatment facility, benefits are available:

- For treatment provided on an intensive outpatient basis, but not including charges related to residential care;
- For partial hospitalization treatment, but not including charges related to residential care;
- For sub-acute, medically monitored inpatient treatment for patients whose condition requires four-hour licensed nurse observation, monitoring, and treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Autism Spectrum Disorder Treatment

The following Autism Spectrum Disorder Treatment *coverage description is added:*

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services for the treatment of autism spectrum disorder for children age 18 and younger when Applied Behavior Analysis services are performed by a South Dakota licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation

of board certified behavior analyst. Autism spectrum disorder is a complex neurodevelopmental medical disorder characterized by social impairment, communication difficulties, and restricted, repetitive, and stereotyped patterns of behavior.

Benefits Maximum:

- Applied Behavior Analysis (ABA) services for the treatment of autism spectrum disorders for children age 18 and younger:
  - For children through age six: **$36,000** per calendar year.
  - For children age seven through age 13: **$25,000** per calendar year.
  - For children age 14 through age 18: **$12,500** per calendar year.

Not Covered:

- Supervisory services performed by a South Dakota licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst in the course of providing Applied Behavior Analysis services.
- Applied Behavior Analysis services for the treatment of autism spectrum disorder for children age 19 and older.
- Applied Behavior Analysis services other than for the treatment of autism spectrum disorder.

Chemical Dependency Treatment

T*he following is revised:*

For treatment in a residential treatment facility, benefits are available:

- For treatment provided on an intensive outpatient basis, but not including charges related to residential care;
- For partial hospitalization treatment, but not including charges related to residential care;
- For sub-acute, medically monitored inpatient treatment for patients whose condition requires four-hour licensed nurse observation, monitoring, and treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Hospitals and Facilities

Nursing Facility*, under the* Details – Covered and Not Covered *section of your coverage manual or SPD is revised:*

> **Nursing Facility.** This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis. The facility must be licensed as a nursing facility under applicable law.

Residential Treatment Facility*, under the* Details – Covered and Not Covered *section of your coverage manual or SPD is revised:*

> **Residential Treatment Facility.** This is a licensed facility other than a hospital or nursing facility that provides:
>
> - treatment on an intensive outpatient basis;
> - partial hospitalization treatment;
> - sub-acute, medically monitored inpatient treatment for patients whose condition requires four-hour licensed nurse observation, monitoring, and treatment, as well as services provided by

interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program;
- inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

T*he following is added to the list of facilities:*

Urgent Care Center. This type of facility provides medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

Mental Health Services

T*he following is revised:*

For treatment in a residential treatment facility, benefits are available:

- For treatment provided on an intensive outpatient basis, but not including charges related to residential care;
- For partial hospitalization treatment, but not including charges related to residential care;
- For sub-acute, medically monitored inpatient treatment for patients whose condition requires four-hour licensed nurse observation, monitoring, and treatment, as well as services provided by interdisciplinary staff under the direction of a licensed physician, but which does not require the full resources of an acute care general hospital or a medically managed inpatient treatment program; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Nonmedical Services

The following is added to the description of Nonmedical Services:

You are also not covered for services delivered to you by a provider via interactive audio only, audio-visual technology, or web-based or similar electronic-based communication network.

General Conditions of Coverage, Exclusions, and Limitations

General Exclusions – Nonmedical Services

The following is added to the description of Nonmedical Services:

You are also not covered for services delivered to you by a provider via interactive audio only, audio-visual technology, or web-based or similar electronic-based communication network.

Notification Requirements and Care Coordination

Case Management

Case Management*, under the* Notification Requirements and Care Coordination *section of your coverage manual or SPD is deleted and replaced with the following:*

Purpose	Case management is intended to identify and assist members with the most severe illnesses or injuries by collaborating with members, members' families, and providers to develop individualized care plans.

Applies to	A wide group of members including those who have experienced potentially preventable emergency room visits; hospital admissions/readmissions; those with catastrophic or high cost health care needs; those with potential long term illnesses; and those newly diagnosed with health conditions requiring life-time management. Examples where case management might be appropriate include but are not limited to: Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Pregnancy (high risk) Transplants
Person Responsible	You, your physician, and the health care facility can work with Wellmark's case managers. Wellmark may initiate a request for case management.
Process	Members are identified and referred to the Case Management program through customer service and claims information, referrals from providers or family members, and self-referrals from members.
Importance	Case management is intended to identify and coordinate appropriate care and care alternatives including reviewing medical necessity; negotiating care and services; identifying barriers to care including contract limitations and evaluation of solutions outside the health plan; assisting the member and family to identify appropriate community-based resources or government programs; and assisting members in the transition of care when there is a change in coverage.

Exception Process for Noncovered Drugs

Exception Process for Noncovered Drugs*, under the* Notification Requirements and Care Coordination *section of your coverage manual or SPD is deleted.*

Claims

Submitting Claims

The explanation of where to submit prescription drug claims, under How to File a Claim*, is deleted and replaced with the following:*

Blue Rx Prescription Drug Claims. Send the claim to the address printed on the claim form.

Exception Requests for Non-Formulary Prescription Drugs

The following is added under the Claims *section of your coverage manual or SPD:*

Prescription drugs that are not listed on the Wellmark Blue Rx Drug List are not covered. However, you may submit an exception request for coverage of a non-formulary drug (i.e., a drug that is not included on the Wellmark Blue Rx Drug List). The form is available at *Wellmark.com* or by calling the Customer

Service number on your ID card. Your prescribing physician or other provider must provide a clinical justification supporting the need for the non-formulary drug to treat your condition. The provider should include a statement that:

- All covered formulary drugs on any tier have been ineffective; or
- All covered formulary drugs on any tier will be ineffective; or
- All covered formulary drugs on any tier would not be as effective as the non-formulary drug; or
- All covered formulary drugs would have adverse effects.

Wellmark will respond within 72 hours of receiving the Exception Request for Non-Formulary Prescription Drugs form. For expedited requests, Wellmark will respond within 24 hours.

In the event Wellmark denies your exception request, you and your provider will be sent additional information regarding your ability to request an independent review of our decision. If the independent reviewer approves your exception request, we will treat the drug as a covered benefit for the duration of your prescription. You will be responsible for out of pocket costs (for example: deductible, copay, or coinsurance, if applicable) as if the non-formulary drug is on the highest tier of the Wellmark Blue Rx Drug List. Amounts you pay will be counted toward any applicable out-of-pocket maximums. If the independent reviewer upholds Wellmark's denial of your exception request, the drug will not be covered, and this decision will not be considered an adverse benefit determination, and will not be eligible for further appeals. You may choose to purchase the drug at your own expense.

The Exception Request for Non-Formulary Prescription Drugs process is only available for FDA-approved prescription drugs that are not on the Wellmark Blue Rx Drug List. It is not available for items that are specifically excluded under your benefits, such as cosmetic drugs, convenience packaging, non-FDA approved drugs, infused drugs, most over-the-counter medications, nutritional, vitamin and dietary supplements, or antigen therapy. The preceding list of excluded items is illustrative only and is not a complete list of items that are not eligible for the process.

Coordination of Benefits

Other Coverage

The following is added under Other Coverage *under the* Coordination of Benefits *section of your coverage manual or SPD:*

When you receive services, you must inform us that you have other coverage, and inform your health care provider about your other coverage. Other coverage includes:

- Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

Rules of Coordination – Dependent Children

The following is added under Dependent Children *under the* Coordination of Benefits *section of your coverage manual or SPD:*

To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined in the *Dependent Children* section.
- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child's coverage under the spouse's plan

began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of the *Dependent Children* section, to the dependent child's parent or parents and the dependent's spouse.

Appeals

The South Dakota Division of Insurance address has changed. Therefore, the new address replaces the old address under External Review *and under* Assistance and Legal Action:

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, SD 57501

General Provisions

Subrogation

Right of Reimbursement

The first paragraph under Right of Reimbursement *is deleted and replaced with the following:*

If you have an illness or injury as a result of the act of a third party or arising out of obligations you have under a contract and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse Wellmark for all benefits paid for the illness or injury from money received from the third party or its insurer, or under the contract, to the extent of the amount paid by Wellmark on the claim.

Procedures for Subrogation and Reimbursement

The first paragraph and the first bullet under that paragraph under Procedures for Subrogation and Reimbursement *are deleted and replaced with the following:*

You or your legal representative must do whatever Wellmark requests with respect to the exercise of Wellmark's subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform Wellmark in writing if you have an illness or injury caused by a third party or arising out of obligations you have under a contract. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such illness or injury to Wellmark as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;

The following provision is added:

Submitting a Complaint

If you are dissatisfied or have a complaint regarding our products or services, call the Customer Service number on your ID card. We will attempt to resolve the issue in a timely manner. You may also contact Customer Service for information on where to send a written complaint.

Glossary

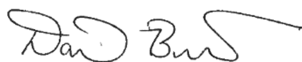
The following definition is added:

Urgent Care Centers provide medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room.

The definition of Spouse *is deleted and replaced with the following:*

Spouse. A man or woman lawfully married to a covered member.

All other terms and provisions of your coverage manual or SPD, including any amendments we may have issued previously, remain unaltered and in effect.



David S. Brown
Executive Vice President, Chief Financial Officer and Treasurer
Wellmark Blue Cross and Blue Shield of South Dakota