Fields of Opportunities

# STATE OF IOWA

CHESTER J. CULVER
GOVERNOR

PATTY JUDGE
LT. GOVERNOR

SUSAN E. VOSS
COMMISSIONER OF INSURANCE

## Legislative Commission on Affordable Health Care Plans for Small Businesses and Families
## Request for Additional Information
## July 18, 2007

1. Spread sheet providing a break down of individual, small and large insurance groups.

   ATTACHMENT

2. Cost impact on small employers with the mental health parity for biologically-based diseases.

   The cost of that benefit is estimated to be 1.88%

3. Medical services to which external review applies and the number of external reviews.

   The exclusions are as follows:

   *This chapter does not apply to a hospital confinement indemnity, credit, dental, vision, long-term care, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.*

   External review only applies when a claim is denied for the reason of "medical necessity". An amendment was passed this year as part of the Division's omnibus that prohibits providers from filing when a claim is denied and the consumer is then not liable for payment because of provider contracts with the carrier. The following medical services have been the top subjects of external review: physical/speech therapy; behavioral/mental health; eating disorders; cosmetic/reconstructive; and chiropractic.

   2006: 39 upheld 9
   2005: 31 upheld 18
   2004: 46 upheld 22
   2003: 45 upheld 22

4. Coverage and exclusion of typical/average health plan.

   ATTACHED

5. Definition of underinsured.

*Although there is no universally accepted definition, the term "underinsurance" is generally used to refer to health care insurance that requires excessive out-of-pocket expenditures, that has significant limits with respect to what health care services are covered, or that fails to cover health care expenses that are perceived by the insured person to be essential for his or her health.*[7]

*Ward et al*[7] *summarized the literature and provided what they termed "attitudinal" and "economic" definitions of underinsurance. Attitudinal definitions emphasize consumer perceptions and satisfaction as they relate to health care. Underinsurance is identified when the health benefit the person prefers to receive is not covered by insurance, when there is a symptom the person thinks requires treatment for which insurance coverage of treatment is not provided, or when a person is dissatisfied with the insurance plan. Economic definitions focus on a person's ability to pay for health care, including the cost of the insurance premiums, copayments, and deductibles. An economic definition of underinsurance defines a limit above which the expense of health care coverage becomes a burden and interferes with access to care. With this definition, underinsurance is identified when out-of-pocket expenses for necessary medical care exceed a specified percentage of the person's income within a given time frame or when a person delays health care because of out-of-pocket costs associated with the services.*

Ward A, Beebe TJ, Blewett LA, Smaida S. *Issues in Defining and Measuring Adequacy of Coverage* Minneapolis, MN: State Health Access Data Assistance Center; 2002

6. Overall total dollars spent on health care in Iowa/ dollar figure and market share of ERISA and non-ERISA covered lives.

   Information not available.

7. Mini-health care plans in Iowa.

   The Division has seen some plans with a very limited life-time maximum and extremely limited coverage but not very many.

## Snap shot: YE 2006
## Covered lives as opposed to # of contracts

| Individual Insurance | | |
|---|---|---|
| Age | # Males | # Females |
| 0-19 | 21,492 | 20,464 |
| 20-25 | 7,727 | 5,532 |
| 26-30 | 4,271 | 2,762 |
| 31-35 | 3,664 | 2,801 |
| 36-40 | 4,127 | 3,532 |
| 41-45 | 5,285 | 4,692 |
| 46-50 | 6,653 | 5,474 |
| 51-55 | 7,045 | 5,949 |
| 56-60 | 6,496 | 6,843 |
| 61-64 | 4,688 | 6,962 |
| Total | 71,448 | 65,011 |

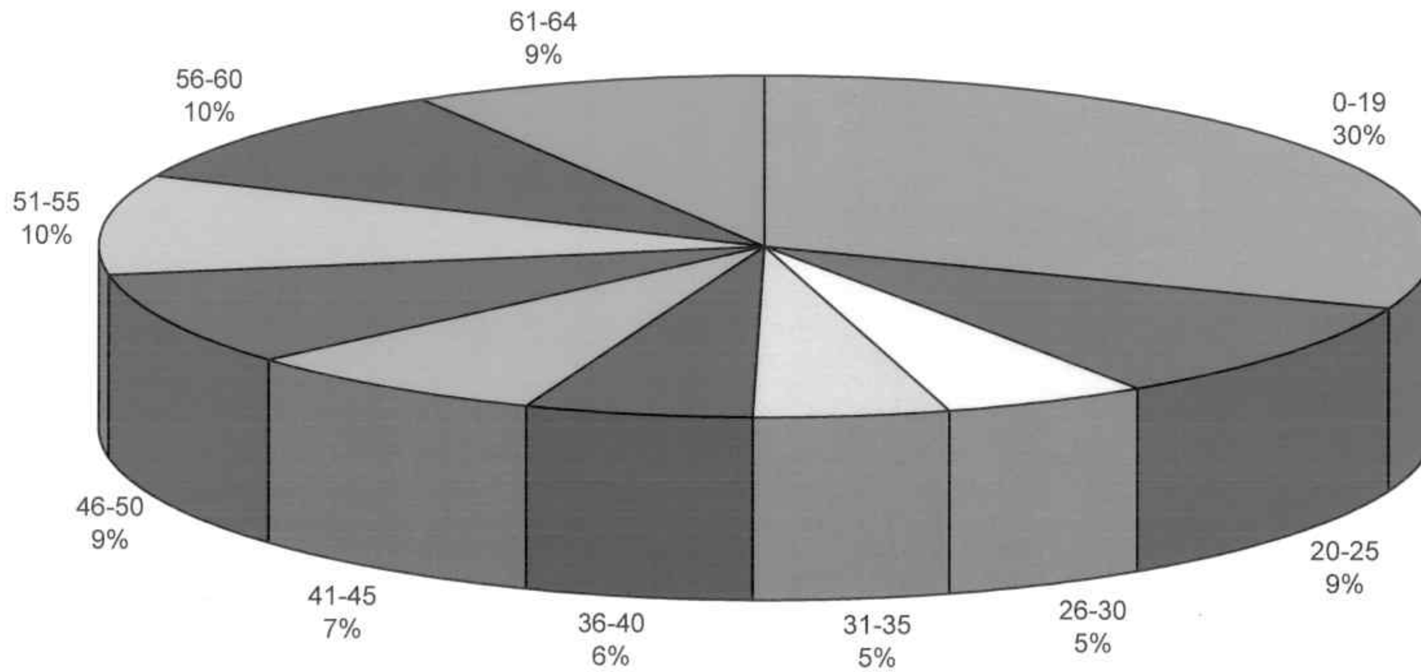
| Small Group (2-50) | | |
|---|---|---|
| Age | # Males | # Females |
| 0-19 | 28,314 | 24,863 |
| 20-25 | 9,014 | 7,322 |
| 26-30 | 8,250 | 6,429 |
| 31-35 | 7,637 | 6,209 |
| 36-40 | 8,152 | 7,065 |
| 41-45 | 9,245 | 8,296 |
| 46-50 | 10,077 | 8,777 |
| 51-55 | 8,706 | 7,675 |
| 56-60 | 6,521 | 5,848 |
| 61-64 | 3,410 | 2,976 |
| | 99,325 | 85,458 |

| Large Group | | |
|---|---|---|
| Age | # Males | # Females |
| 0-19 | 65,339 | 59,281 |
| 20-25 | 14,864 | 17,606 |
| 26-30 | 13,699 | 15,834 |
| 31-35 | 13,527 | 15,137 |
| 36-40 | 14,771 | 16,214 |
| 41-45 | 16,727 | 19,228 |
| 46-50 | 17,952 | 21,302 |
| 51-55 | 17,715 | 20,818 |
| 56-60 | 15,107 | 17,206 |
| 61-64 | 7,820 | 8,513 |
| | 197,521 | 211,138 |

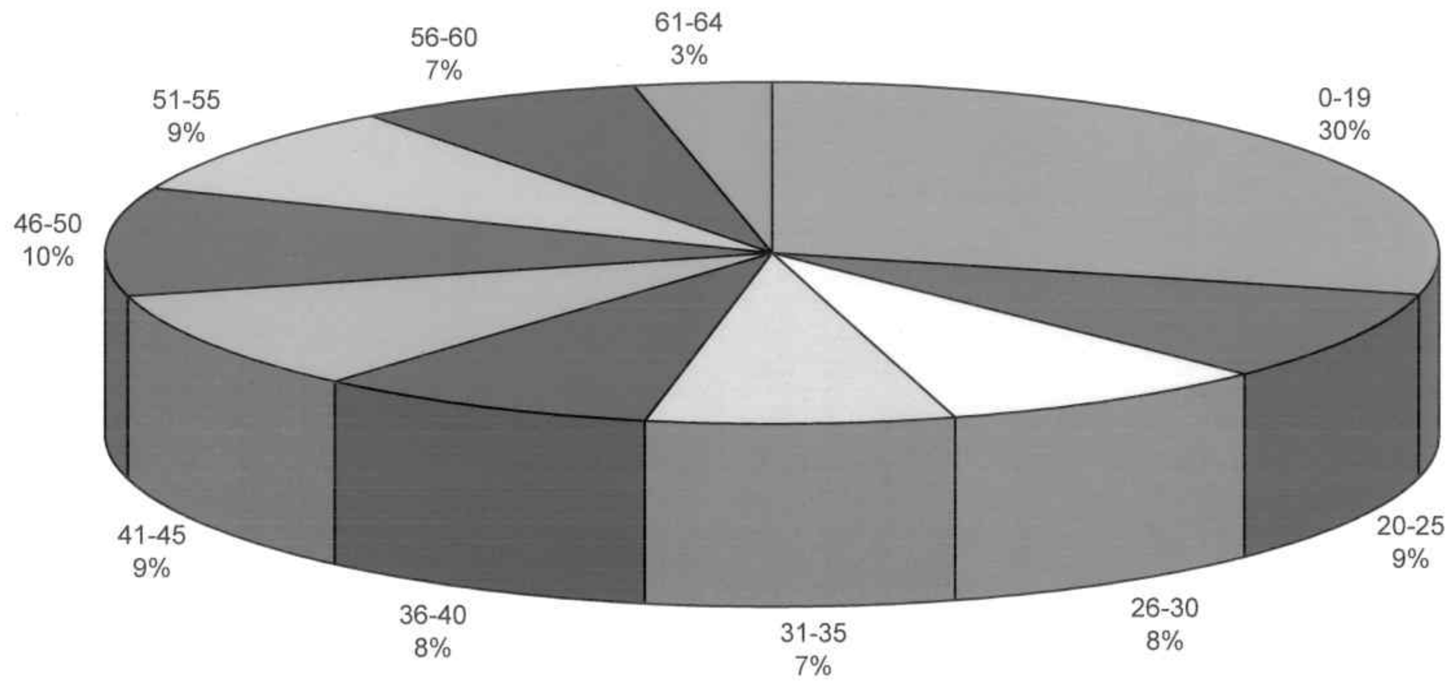
| Self-Insured | | |
|---|---|---|
| Age | # Males | # Females |
| 0-19 | 92,608 | 85,514 |
| 20-25 | 19,259 | 20,226 |
| 26-30 | 17,430 | 18,356 |
| 31-35 | 18,749 | 18,808 |
| 36-40 | 21,195 | 21,065 |
| 41-45 | 23,954 | 24,663 |
| 46-50 | 25,557 | 26,967 |
| 51-55 | 23,910 | 25,142 |
| 56-60 | 19,853 | 21,079 |
| 61-64 | 11,532 | 11,866 |
| Total | 274,048 | 273,686 |

Item #1

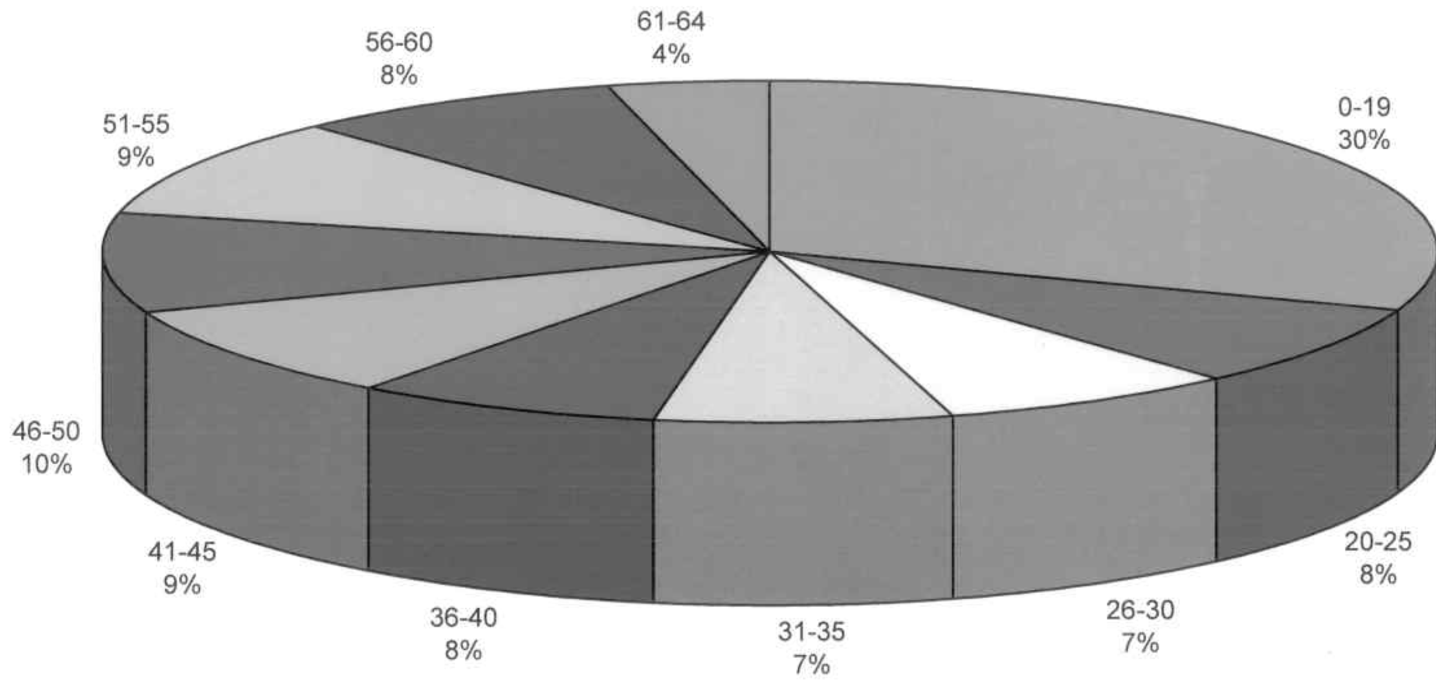
# Individual Insurance by Age



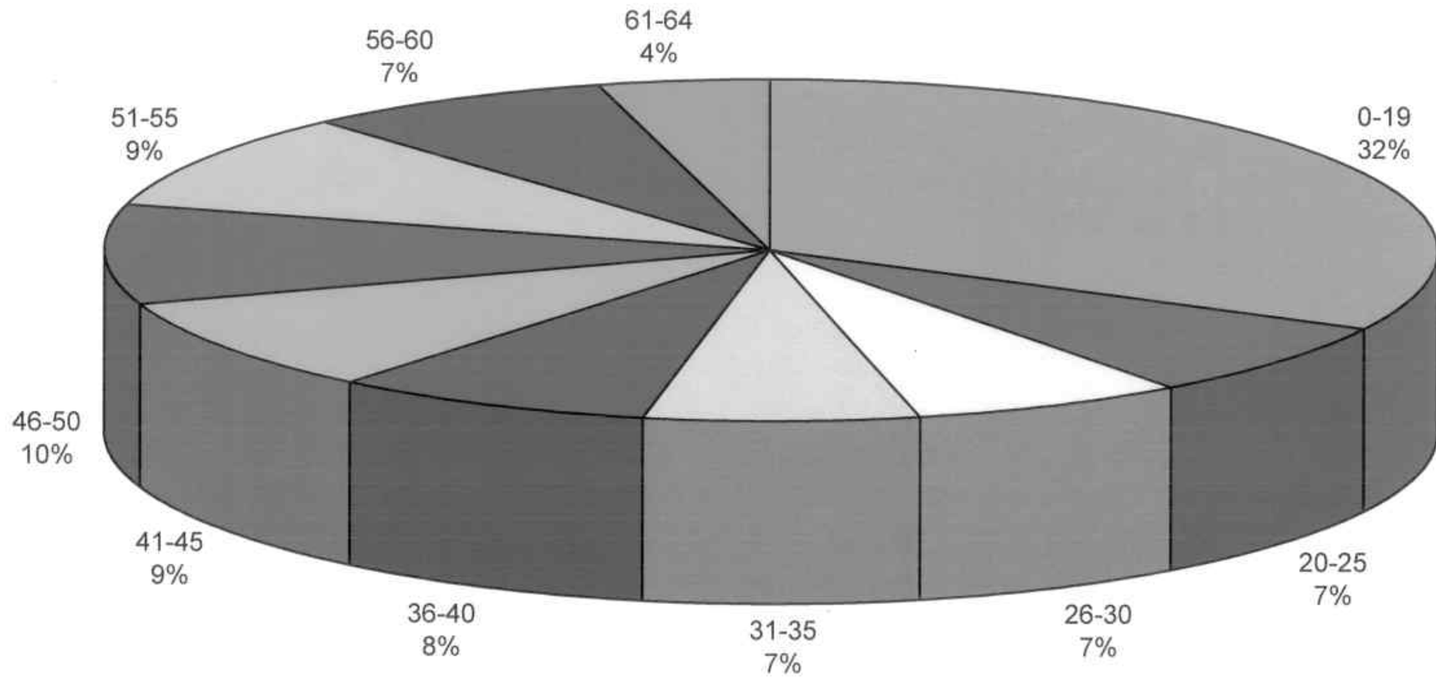
# Small Group (2-50) by Age



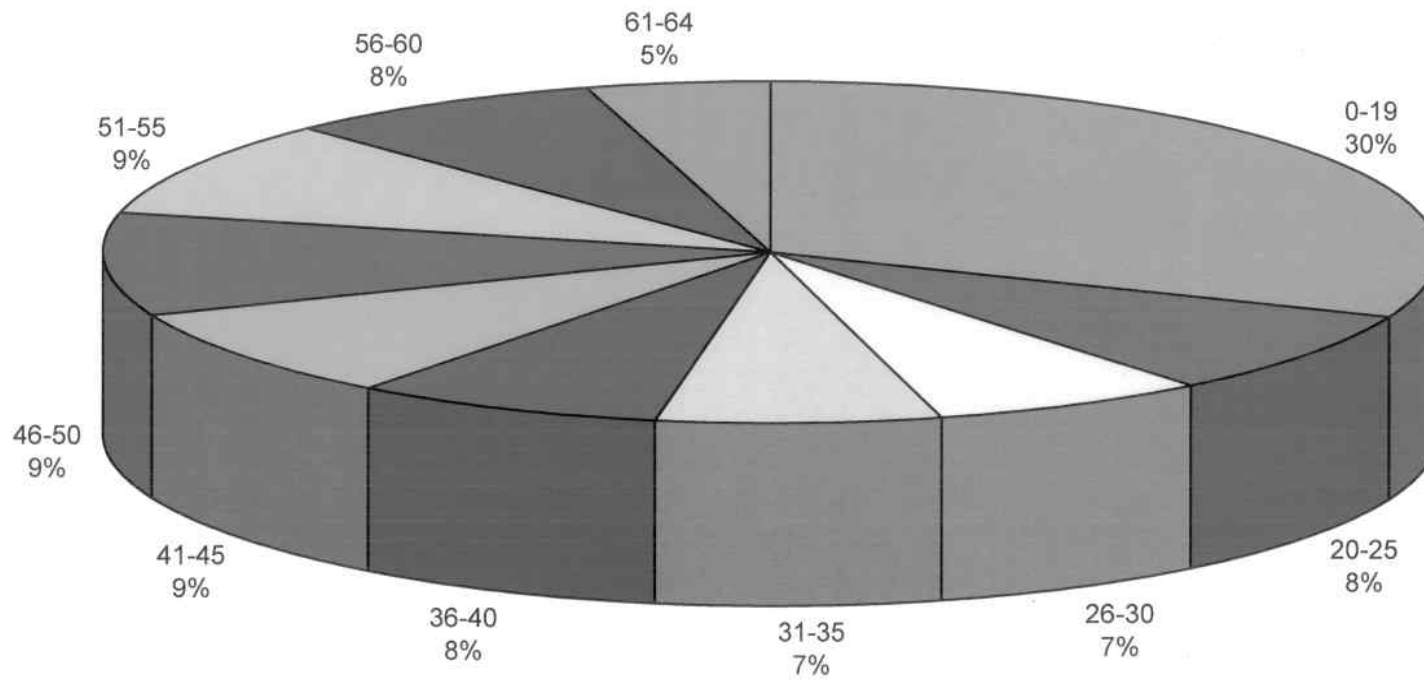
# Large Group by Age

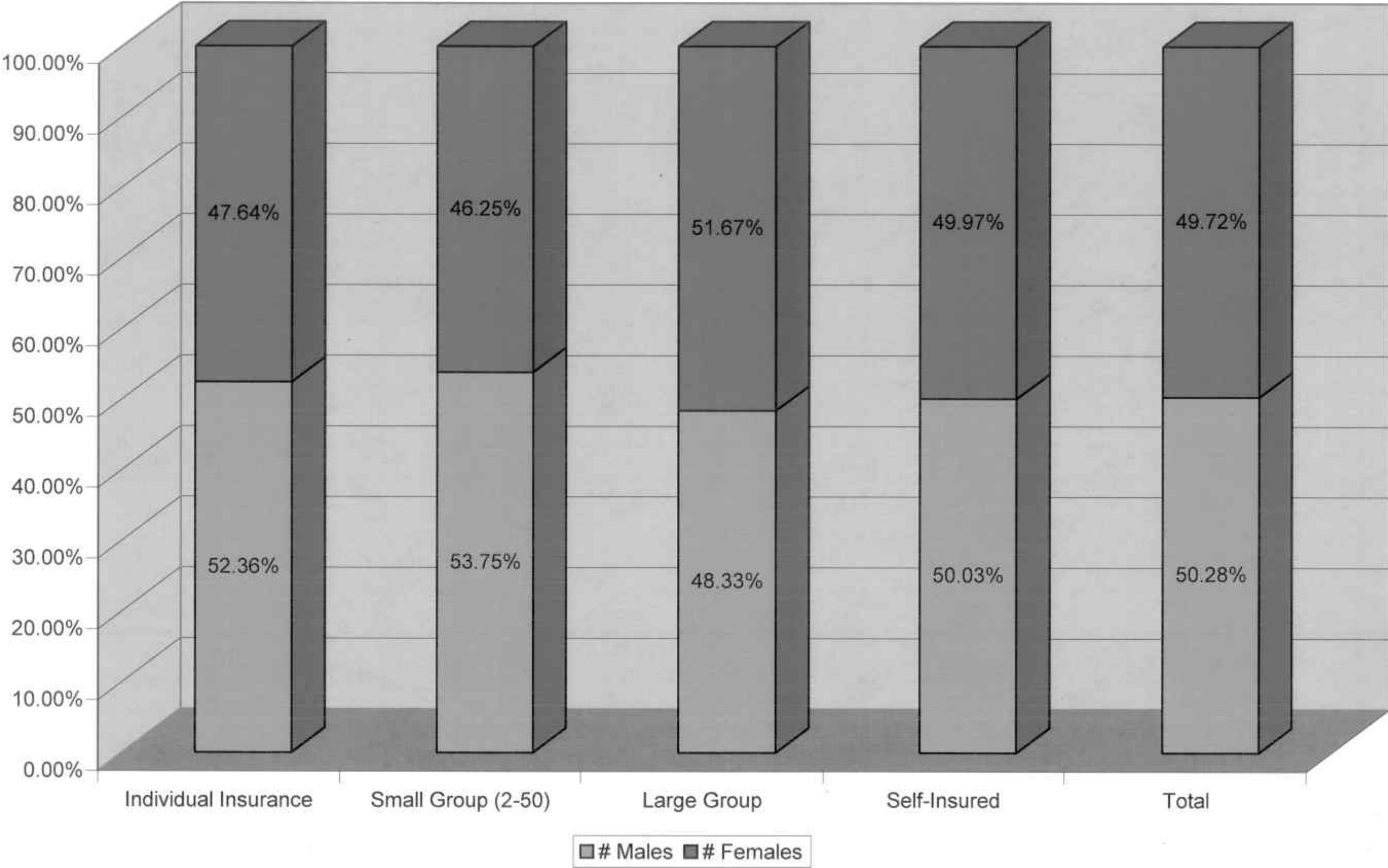


# Self-Insured by Age

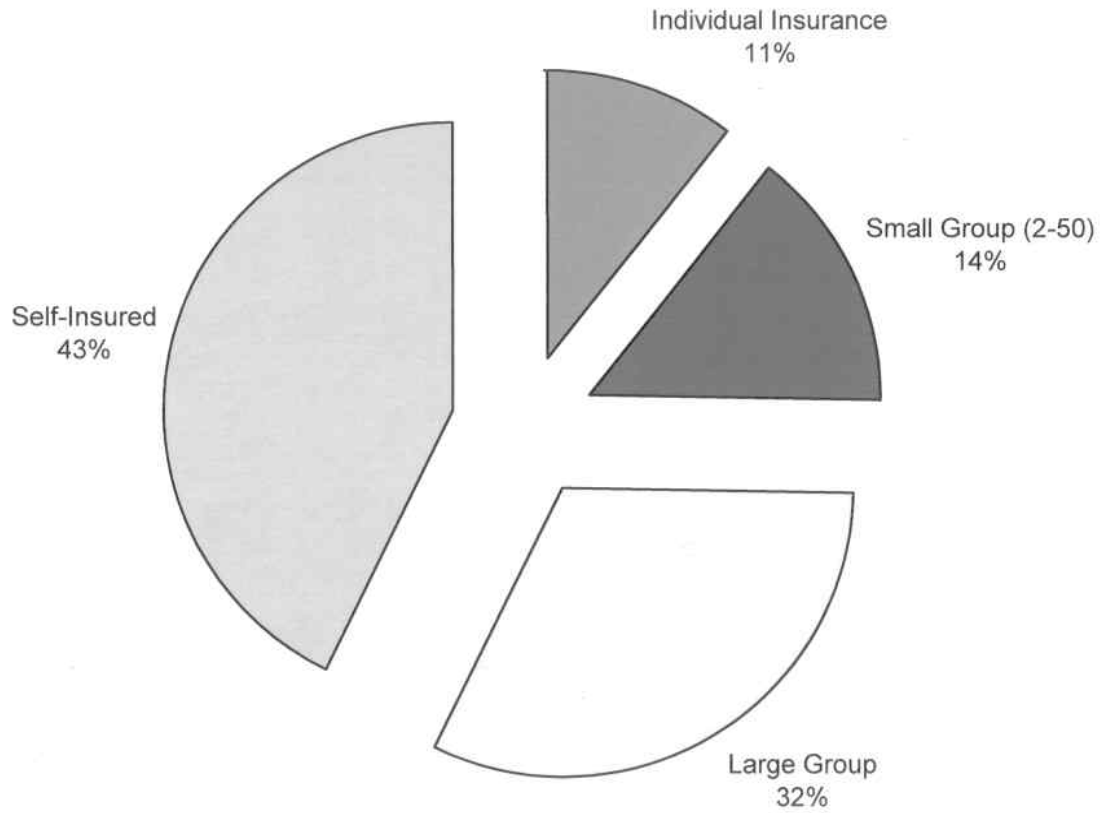


# Aggregate total by Age




Number of Insured by Gender
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
47.64%
46.25%
51.67%
49.97%
49.72%
52.36%
53.75%
48.33%
50.03%
50.28%
Individual Insurance
Small Group (2-50)
Large Group
Self-Insured
Total
# Males
# Females

# Insured by plan type



## Snap shot: YE 2006
## Covered lives as opposed to # of contracts

**Individual Insurance**

| Age | # Males | # Females | | |
|---|---|---|---|---|
| 0-19 | 21,492 | 20,464 | 41,956 | 30.75% |
| 20-25 | 7,727 | 5,532 | 13,259 | 9.72% |
| 26-30 | 4,271 | 2,762 | 7,033 | 5.15% |
| 31-35 | 3,664 | 2,801 | 6,465 | 4.74% |
| 36-40 | 4,127 | 3,532 | 7,659 | 5.61% |
| 41-45 | 5,285 | 4,692 | 9,976 | 7.31% |
| 46-50 | 6,653 | 5,474 | 12,127 | 8.89% |
| 51-55 | 7,045 | 5,949 | 12,994 | 9.52% |
| 56-60 | 6,496 | 6,843 | 13,339 | 9.78% |
| 61-64 | 4,688 | 6,962 | 11,650 | 8.54% |
| Total | 71,448 | 65,011 | 136,458 | 1 |
| | 52.36% | 47.64% | | |

**Small Group (2-50)**

| Age | # Males | # Females | | |
|---|---|---|---|---|
| 0-19 | 28,314 | 24,863 | 53,177 | 28.78% |
| 20-25 | 9,014 | 7,322 | 16,336 | 8.84% |
| 26-30 | 8,250 | 6,429 | 14,679 | 7.94% |
| 31-35 | 7,637 | 6,209 | 13,846 | 7.49% |
| 36-40 | 8,152 | 7,065 | 15,217 | 8.23% |
| 41-45 | 9,245 | 8,296 | 17,540 | 9.49% |
| 46-50 | 10,077 | 8,777 | 18,854 | 10.20% |
| 51-55 | 8,706 | 7,675 | 16,380 | 8.86% |
| 56-60 | 6,521 | 5,848 | 12,369 | 6.69% |
| 61-64 | 3,410 | 2,976 | 6,385 | 3.46% |
| Total | 99,325 | 85,458 | 184,783 | 1 |
| | 53.75% | 46.25% | | |

**Large Group**

| Age | # Males | # Females | | |
|---|---|---|---|---|
| 0-19 | 65,339 | 59,281 | 124,620 | 30.49% |
| 20-25 | 14,864 | 17,606 | 32,470 | 7.95% |
| 26-30 | 13,699 | 15,834 | 29,533 | 7.23% |
| 31-35 | 13,527 | 15,137 | 28,664 | 7.01% |
| 36-40 | 14,771 | 16,214 | 30,985 | 7.58% |
| 41-45 | 16,727 | 19,228 | 35,955 | 8.80% |
| 46-50 | 17,952 | 21,302 | 39,254 | 9.61% |
| 51-55 | 17,715 | 20,818 | 38,533 | 9.43% |
| 56-60 | 15,107 | 17,206 | 32,312 | 7.91% |
| 61-64 | 7,820 | 8,513 | 16,334 | 4.00% |
| Total | 197,521 | 211,138 | 408,659 | 1 |
| | 48.33% | 51.67% | | |

**Self-Insured**

| Age | # Males | # Females | | |
|---|---|---|---|---|
| 0-19 | 92,608 | 85,514 | 178,123 | 32.52% |
| 20-25 | 19,259 | 20,226 | 39,485 | 7.21% |
| 26-30 | 17,430 | 18,356 | 35,786 | 6.53% |
| 31-35 | 18,749 | 18,808 | 37,556 | 6.86% |
| 36-40 | 21,195 | 21,065 | 42,259 | 7.72% |
| 41-45 | 23,954 | 24,663 | 48,618 | 8.88% |
| 46-50 | 25,557 | 26,967 | 52,524 | 9.59% |
| 51-55 | 23,910 | 25,142 | 49,051 | 8.96% |
| 56-60 | 19,853 | 21,079 | 40,933 | 7.47% |
| 61-64 | 11,532 | 11,866 | 23,398 | 4.27% |
| Total | 274,048 | 273,686 | 547,734 | 1 |
| | 50.03% | 49.97% | | |

**Total**

| Age | # Males | # Females | | |
|---|---|---|---|---|
| 0-19 | 207,753 | 190,122 | 397,876 | 31.14% |
| 20-25 | 50,865 | 50,686 | 101,550 | 7.95% |
| 26-30 | 43,649 | 43,381 | 87,030 | 6.81% |
| 31-35 | 43,577 | 42,954 | 86,531 | 6.77% |
| 36-40 | 48,245 | 47,876 | 96,120 | 7.52% |
| 41-45 | 55,211 | 56,878 | 112,089 | 8.77% |
| 46-50 | 60,240 | 62,519 | 122,759 | 9.61% |
| 51-55 | 57,376 | 59,583 | 116,959 | 9.15% |
| 56-60 | 47,976 | 50,976 | 98,953 | 7.75% |
| 61-64 | 27,450 | 30,317 | 57,767 | 4.52% |
| Total | 642,341 | 635,293 | 1,277,634 | |
| | 50.28% | 49.72% | | |

| | | |
|---|---|---|
| Individual Insurance | 11% | 136,458 |
| Small Group (2-50) | 14% | 184,783 |
| Large Group | 32% | 408,659 |
| Self-Insured | 43% | 547,734 |
| | 100% | 1,277,634 |

| | # Males | # Females |
|---|---|---|
| Individual Insurance | 52.36% | 47.64% |
| Small Group (2-50) | 53.75% | 46.25% |
| Large Group | 48.33% | 51.67% |
| Self-Insured | 50.03% | 49.97% |
| Total | 50.28% | 49.72% |

What does the typical/average health-care plan cover.

Mandates

- Supplemental coverage for adopted or newly born children is required in group and individual plans to includethe necessary care and treatment of medically diagnosed congenital defects and birth abnormalities
- Skilled nursing care is required to be covered in hospitals in group and individual plans if the individual or group plan offers a benefit for skilled nursing care.
- Mammography, examination coverage is required in both individual and group plans.
- Coverage for adopted children is mandated in both group and individual plans.
- Post delivery benefits and care for 48 hours for vaginal birth 96 hours for cesarean birth are mandated in both individual and group insurance.
- Continuity of care for both pregnancy and terminal illness is mandated in group insurance in the event of termination of a provider from the preferred provider list.
- Diabetes coverage.
- Prescription Contraceptive Coverage in group plans that include prescription drug coverage.
- Mandated coverage for dental care-anesthesia and certain hospital expenses in group insurance plans.
- Coverage for biologically based mental illnesses in large group plans.
- Coverage for well-child care in group insurance plans

The State of Iowa has mandated that certain benefits be offered in certain products.

Item # 4

INDIVIDUAL

# benefits

Wellmark Outline of Coverage

### Approved Hospital/Health Care Facility Services

The Alliance Select program provides medically necessary services and supplies related to the treatment of an illness or injury as an inpatient in a facility.

Approved health care facilities include ambulatory surgical facilities, hospitals, and nursing facilities.

*Comprehensive* plans also consider community mental health centers and facilities for treatment of chemical dependency to be approved health care facilities.

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

### Inpatient Services

**All plans cover:**

- Accidental injury care
- Anesthetics and their administration
- Blood administration
- Chemotherapy services
- Complications of pregnancy
- Corneal grafts
- Dietary services
- Dressing and casts
- Drugs and biologicals
- Emergency care
- General nursing care
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical and surgical supplies
- Occupational therapy
- 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.*
- Room and meals, including private rooms when medically necessary
- Special care units, including burn, intensive, and cardiac care units

*Comprehensive* plans also include:

- Routine maternity care, including delivery room
- Mental health and chemical dependency services (30-day maximum per benefit period).

### Outpatient Services

**All plans cover:**

- Accidental injury care
- Anesthetics and their administration
- Chemotherapy services
- Complications of pregnancy
- Corneal grafts
- Dressing and casts
- Drugs and biologicals
- Emergency Care
- Hemodialysis services
- Inhalation therapy
- Intravenous injections and solutions
- Medical and surgical supplies
- Physical therapy
- Surgery

*Comprehensive* plans also include:

- Routine maternity care, including delivery room
- Mental health and chemical dependency services (30 visits maximum per benefit period).

### Approved Practitioner Services

Approved practitioners include: advanced registered nurse practitioners, dentists, doctors of osteopathy, medical doctors, occupational therapists, optometrists, oral surgeons, physical therapists, physician assistants, and podiatrists.

The *Enhanced* and *Comprehensive* plans cover chiropractors. For *Comprehensive* plans, clinical psychologists and licensed independent social workers are also approved practitioners.

The following is a list of approved practitioner services for **all plans:**

- Accidental injury services
- Anesthetics and their administration
- Assisting surgeon services
- Chemotherapy
- Complications of pregnancy
- Concurrent care
- Consultation services
- Corneal grafts
- Certain dental services
- Genetic testing and counseling in certain circumstances
- Hemodialysis services
- Mammography x-ray as mandated by Iowa Code:
  - — For women 35-39 years of age: one base line 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.
- Medical emergency care

The *Enhanced* and *Comprehensive* plans also include:

- Allergy treatments
- Chiropractic care
- One mammography x-ray per year per covered person
- One routine physical exam per year
- Well-child care including physical exams, immunizations and laboratory services until the child reaches age 7.

*Comprehensive* plans also include:

- Infertility treatments ($15,000 lifetime maximum)
- Routine maternity care (prenatal and postnatal)
- Temporomandibular joint syndrome (except physical therapy, manipulations, dental extractions, or orthodontic treatment)
- Tubal ligation or vasectomy.

### Other Covered Services for All Plans

General anesthesia and hospital or ambulatory surgical facility services related to the provision of dental services, subject to any other restrictions on dental coverage under your benefits policy, if the member:

- is a child under age 14 who, based on a determination by a licensed dentist and the child's treating physician, has a dental or

developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
- *has, based on a determination* by a licensed dentist and the member's treating physician, one or more medical conditions that would create significant or undue medical risk for the member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.

Other medically necessary covered services and supplies related to the treatment of illness and injury include:
- Ambulance services (professional air or ground)
- Home infusion therapy
- Home medical equipment, including wheelchairs and hospital beds that are purchased or rented
- Home skilled nursing, if given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager.
- Oxygen and equipment
- Prescription drugs and medicines covered under the BlueRx managed prescription drug program
- Prosthetic appliances

### Home Health Services

Coverage includes care provided by an agency accredited by the Joint Commission for Accreditation of Health Care 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 (see limitations on page 5):
- Home health aide services
- Home skilled nursing, if given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency, and if coordinated by a case manager.
- 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.

### Supplemental Accident Option

If you chose the supplemental accidental injury benefit on your application for coverage and you have paid the specific premium for this benefit, you have supplemental accidental injury benefits in the dollar amount specified in your benefits policy. If this supplemental accidental injury benefit applies to you and you are injured accidentally and are treated within 90 days of the accident, covered charges related to such treatment are not subject to a deductible or coinsurance until after the covered charges exceed the supplemental accidental injury benefit amount.

This supplemental accidental injury benefit is applied to covered charges relating to an accidental injury in the order in which such charges are received by us for payment up to the supplemental accidental injury benefit amount specified in your benefits policy. In the event that your benefits policy already covers such charges, the supplemental accidental injury benefit will not be available.

*The supplemental accidental injury benefit* applies only to hospital services, practitioner services, services of a registered nurse (R.N.), x-ray and laboratory services. You do not have supplemental accidental injury benefits for disease or infection (except pyogenic infection caused by an accidental cut or wound), services or supplies excluded by your benefits policy, dental treatment, if currently listed in your benefits policy as not covered for supplemental accidental injury.

### 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, a 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 dieticians 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.

# exclusions

### Counseling

**All Alliance Select plans exclude coverage for:**

- Bereavement counseling or services
- Certain developmental and learning disorders
- Certain disorders of early childhood (such as academic underachievement disorder)
- Communication disorders (such as stuttering and stammering)
- Impulse-control disorders (such as pathological gambling)
- Impotence, except as the result of a physical illness or injury
- Marriage and family counseling
- Nicotine dependence
- Sensitivity, shyness and social withdrawal disorder
- Sexual identification or gender disorders (including sex-change surgery).

The *Enhanced* and *Essential* plans also exclude:

- Chemical dependency treatment
- Treatment for mental health conditions

### Fertility, Infertility and Maternity

**All Alliance Select plans exclude coverage for:**

- Contraceptives used solely for the purpose of preventing conception, unless you purchase the optional contraceptive coverage.
- Services provided for the collection of donor semen, oocytes, or the services of a surrogate parent.
- Sterilization reversal.
- Infertility treatment following voluntary sterilization.

The *Enhanced* and *Essential* plans also exclude coverage for:

- Abortion
- Infertility treatment
- Maternity services—except for complications of pregnancy
- Sterilization

### Miscellaneous

**All Alliance Select plans exclude coverage for:**

- 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 (except pregnancy in Enhanced and Essential plans)
- Dental services except as specified and limited in the policy
- Elastic stockings and bandages
- Hearing aids and exams
- Investigational treatment
- Maxillary and mandibular implants
- Motor vehicle special equipment
- Personal convenience items
- Services furnished to you prior to the date your policy begins
- Travel or lodging costs
- Vision care
- Wigs

The *Enhanced* and *Essential* plans also exclude:

- Temporomandibular Joint Syndrome

The *Essential* plan also excludes:

- Allergy treatments

### Organ Transplants

**All Alliance Select plans exclude coverage for:**

- Expenses for 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

### Preventive and Routine Care

**All Alliance Select plans exclude coverage for:**

- Immunizations for persons age 7 and older
- Routine, periodic physical or health examinations, immunizations or screening procedures that are performed solely for school, sport, employment, insurance, licensing, or travel.
- Routine foot care

The *Essential* plan also excludes:

- Routine examinations
- Well-child care.

### Provider Types

**These providers are excluded on all Alliance Select plans:**

- Provider is an immediate family member

The *Enhanced* and *Essential* plans also exclude these provider types:

- Community mental health centers
- Facilities for the treatment of chemical dependency
- Licensed independent social workers
- Psychologists.

The *Essential* plan also excludes these provider types:

- Chiropractors

### Covered by Other Programs or Laws

**All Alliance Select plans exclude:**

- Military-related injury
- Services or supplies when someone else has the legal obligation to pay for your care
- Services and supplies that are covered or could have been covered under Workers' Compensation laws

The *Enhanced* and *Essential* also exclude:

- Services and supplies when you are entitled to claim benefits from governmental programs (except Medicaid)

**Therapy, Self-Motivation, and Other Programs**

**All Alliance Select plans exclude:**

- Acupuncture
- Cosmetic services and supplies
- Educational or recreational therapy
- Massage therapy
- Occupational therapy supplies
- Speech therapy when services are provided outside of a facility, not coordinated with home health services, or to treat certain developmental, learning, or communication disorders.
- Self-help or self-cure programs
- Weight-reduction programs
- Services and supplies as an inpatient provided primarily for diagnostic evaluation, physical therapy, or occupational therapy.

# notification requirements

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

### Precertification

Precertification is a process whereby you or your provider notify Wellmark Blue Cross and Blue Shield before a planned admission to a nursing facility or acute rehabilitation facility. Precertification is also required before receiving home health services, hospice, or home infusion therapy. During precertification, Wellmark Blue Cross and Blue Shield of Iowa checks benefit eligibility and determines whether medical necessity standards have been met.

### Continued Stay Review

Continued Stay 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 Blue Cross and Blue Shield 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.

### Prior Approval

Before you receive treatment for certain services and supplies, you or your provider should request our prior approval. Prior approval helps determine whether a proposed treatment plan is medically necessary, a benefit of your policy, and ensures you receive full benefits for certain services. A list of services on which we recommend prior approval can be found in your policy.

### Case Management

Alliance Select 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.

# limitations

**Your Alliance Select coverage is limited as follows:**

### Pre-Existing Condition Exclusion Period

You will have an exclusion period of 365 days from the date your policy begins for all pre-existing conditions, including maternity. However, the exclusion period for pre-existing conditions is reduced or waived if:

- You have qualifying previous coverage as defined in your policy, and
- Your qualifying previous coverage was continuous within 63 days prior to the date when your new coverage began.

**Please note:** These plans are medically underwritten. When you apply for one of these plans, we will do one of the following:

- Approve coverage; or
- Offer coverage at a substandard (higher) premium; or
- Deny coverage; or
- Offer you a policy amendment, that is, an "Amended Application," that limits or excludes coverage for a particular condition. (If you accept the policy amendment, or amended application, any services you receive for that condition will be denied for as long as that amendment is in effect, without regard to any pre-existing condition exclusion period.)

### Organ Transplant Coverage

Coverage is available under all Alliance Select plans for transplants of the heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, and liver and for certain autologous and allogeneic bone marrow/stem cell transfer transplants. **Other limitations that apply to transplants include:**

- Services for transportation in an ambulance to a transplant center are limited to a $10,000 maximum per transplant.
- You should follow written prior approval requirements for all transplants, except kidney.

The *Essential* plan includes a $500,000 lifetime maximum for transplants.

### Home Health Services/Nursing Facilities

If you choose the *Essential* plan:

- Home Health Services are limited to 60 visits per person per benefit period.
- Number of days in a nursing facility is limited to 30 days per benefit period.

### Treatment of Mental Health Conditions and Chemical Dependency (MH/CD)

Only *Comprehensive* plans provide coverage for mental health and chemical dependency treatment. This coverage is subject to these limitations:

- Inpatient coverage for mental health and chemical dependency is limited to 30 days for each covered person in a benefit period.
- You are not covered for residential treatment of mental health conditions or chemical dependency. *Residential treatment* means treatment of mental health conditions or chemical dependency is treatment for severe, persistent, or chronic mental conditions or chemical dependency; provided in a 24-hour residential setting; involves therapeutic intervention and specialized programming with a high degree of structure and supervision; includes training in basic skills, such as social skills and activities of daily living; and does not require daily supervision of a physician.
- Coverage for each covered person is limited to 30 visits in a benefit period for the outpatient treatment of mental health conditions and chemical dependency.

### Infertility Treatment

Only *Comprehensive* plans provide coverage for services or supplies related to the diagnosis or treatment of female or male infertility. This coverage is limited to a lifetime maximum of $15,000 per covered person.

Coinsurance for infertility services does not apply to your out-of-pocket maximum and continues even when your out-of-pocket maximum is met.

### Respite Care

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

### Cosmetic Surgery

Cosmetic Surgery is limited to corrective surgery that has the purpose of restoring function lost or impaired as a result of an illness, accidental injury, or defect.

### Morbid Obesity

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.

Before receiving weight reduction surgery, we recommend that you or someone acting on your behalf request Prior Approval.

### 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 was performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy.