
Wellmark Blue Cross and Blue Shield of Iowa

Medicare Supplement Enrollment and Administrative Guide

- including MedicareBlue SupplementSM Products

**QUICK REFERENCE: WELLMARK CONTACT LIST
FOR INDEPENDENT AGENTS ONLY***

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* **Please note:** Third-party marketing organizations will follow the processing guidelines pursuant to their contractual agreements with Wellmark, Inc.

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Enrollment

Eligibility

General Requirements

To qualify for a Wellmark Blue Cross and Blue Shield of Iowa policy supplemental to Medicare, a person must be:

- Age 65 or older, *or* under age 65 with a disability
- Enrolled in Medicare Parts A and B
- A [resident of the state of Iowa](#) (for information about members moving to or from Iowa, see “[Member Transfers Between Plans](#)” section below)
- Applying no earlier than 120 days prior to the desired effective date of the policy (see also “[Effective Dates](#)” section below).

Unless eligible for conversion or guaranteed issue rights, applicant must answer health questions contained in sections D and/or E of the Application for MedicareBlue Supplement (M-53314). When answering health questions, please note the following:

- § If one or more questions in Section D of the Application for MedicareBlue Supplement (M-53314) are checked “yes,” the new applicant or existing member may *only* choose MedicareBlue SupplementSM (guaranteed issue) Plan A.
 - § If one or more health conditions in Section E of the Application for MedicareBlue Supplement (M-53314) are checked, the new applicant or existing member is eligible for MedicareBlue SupplementSM Plans A, D, F, F-High Deductible, and N at the standard premium rate.
 - § If all questions in Sections D and E of the Application for MedicareBlue Supplement (M-53314) are answered “no,” the applicant is eligible for MedicareBlue SupplementSM Plans D, F, F-High Deductible, and N at the preferred premium rate.
-

Guaranteed Issue Rights Situations

Note: Tobacco use question on member application is **not** used for rating when member enrolls due to an event that makes him/her eligible for Guarantee Issue Rights.

Medicare Supplement Open Enrollment Period

Qualifying Criteria	Open Enrollment Time Period	Plans Available <i>without</i> answering health questions
Applicant attains or is already age 65 or older and is enrolled in Medicare Parts A and B	<p>No later than 6 months after the person's Part B effective date (6 month guaranteed enrollment period)</p> <p>(For example, if a person's 65th birthday falls on May 20 and Medicare Part B enrollment is May 1, that person may submit an application between February 1—120 days prior--and November 1 without answering health questions.)</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate

Please note: If a person is eligible to enroll in Medicare, but chooses not to enroll, he/she is **not** eligible for MedicareBlue SupplementSM.

Please note: Under age 65 disabled applicants do not have any open enrollment period. For MedicareBlue SupplementSM products *other than* Plan A (guaranteed issue), applicants must answer health questions to determine eligibility.

If the under 65 disabled member enrolling in MedicareBlue Supplement has previously been covered under a Wellmark two-person or family contract, the remaining covered family members will be established on a new plan. Underwriting on the remaining covered family members is not required if they enroll in the same or lesser benefits and submit an application within 31 days of the Medicare event. A new application is required for these family members.

Note: Under age 65 disabled members will be entitled to the Medicare Supplement six-month guaranteed enrollment period upon reaching age 65.

Other Guaranteed Issue Rights Situations

Event that triggers Guaranteed Issue Rights Qualifying Criteria	Medicare Supplement Guaranteed Issue Time Period	Plans Available <i>without</i> answering health questions
<p>Applicant regardless of age is enrolled in Medicare Parts A and B, resides in Iowa, and was enrolled in an employer-sponsored group plan or COBRA with any carrier that provided benefits to supplement (i.e., secondary to) Medicare and no longer has coverage due to:</p> <ul style="list-style-type: none"> • The plan was terminated by the employer; or • Applicant's COBRA eligibility has expired (Note: if applicant voluntarily elects to cancel COBRA and/or stops paying premiums, Medicare Supplement guaranteed issue right does not apply); or • The plan ceased to provide some or all of the benefits that supplement the benefits under Medicare; or • The plan changed carriers resulting in reduced benefits; or • The plan changed to a plan with a more restrictive network, causing the retiree to reside outside of the plan's service area 	<p>Begins the later of:</p> <ul style="list-style-type: none"> • the date that the individual receives notice of termination, or • cessation of some or all health benefits, or • the date the termination or cessation is effective <p>and ends on the date that is 63 days after the date the coverage is terminated or ceases.</p> <p>Note: Proof of termination or change must accompany the application.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate

Event that triggers Guaranteed Issue Rights Qualifying Criteria	Medicare Supplement Guaranteed Issue Time Period	Plans Available <i>without</i> answering health questions
<p>Applicant enrolled in a Medicare Advantage plan, a Medicare risk or cost contract plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Medicare Select and is involuntarily terminated or otherwise discontinued due to:</p> <ul style="list-style-type: none"> • The certification of the company has been terminated; or • The plan has been terminated; or • The plan changed its service area and the enrollee no longer resides in the new service area. 	<p>Begins on the date the individual receives notice of termination and ends 63 days after the date the applicable coverage is terminated.</p> <p>Note: Proof of termination or change must accompany the application.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate
<p>Applicant enrolled in a Medicare Advantage plan, a Medicare risk or cost contract plan, a Program of All-Inclusive Care for the Elderly (PACE), or a Medicare Select and is terminated due to:</p> <ul style="list-style-type: none"> • the applicant moves out of the plan's service area; or • company seriously violates the contract; or • company or agent misrepresents the plan during marketing. 	<p>Begins on:</p> <ul style="list-style-type: none"> • 60 days before effective date of the disenrollment <p>and ends on the date that is 63 days after the effective date.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate

Event that triggers Guaranteed Issue Rights Qualifying Criteria	Medicare Supplement Guaranteed Issue Time Period	Plans Available <i>without</i> answering health questions
<p>Applicant enrolled in a Medicare supplement plan is involuntarily terminated due to:</p> <ul style="list-style-type: none"> The issuer becomes insolvent or the non-issuer organization declares bankruptcy. 	<p>Begins on the earlier of:</p> <ul style="list-style-type: none"> the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency (or, if such notice is not received, notice that a claim has been denied because of such a termination or insolvency), or the date the termination is effective <p>and ends on the date that is 63 days after the date the coverage is terminated.</p> <p>Note: Proof of termination or change must accompany the application.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> Plan A (guaranteed issue) Plan D preferred premium rate Plan F preferred premium rate Plan F-High Deductible preferred premium rate Plan N preferred premium rate
<p>Applicant enrolled in a Medicare supplement plan voluntarily disenrolls due to:</p> <ul style="list-style-type: none"> the company or agent misrepresents the plan during marketing. 	<p>Begins on:</p> <ul style="list-style-type: none"> 60 days before effective date of the disenrollment <p>and ends on the date that is 63 days after the effective date.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> Plan A (guaranteed issue) Plan D preferred premium rate Plan F preferred premium rate Plan F-High Deductible preferred premium rate Plan N preferred premium rate

Event that triggers Guaranteed Issue Rights Qualifying Criteria	Medicare Supplement Guaranteed Issue Time Period	Plans Available <i>without</i> answering health questions
<p>Applicant joined a Medicare Advantage plan or in a Program of All-Inclusive Care for the Elderly (PACE) when first eligible for Medicare Part B at age 65 or older, and voluntarily disenrolls:</p> <ul style="list-style-type: none"> • Within 12 months of joining by switching to original Medicare (trial right). 	<p>Begins on:</p> <ul style="list-style-type: none"> • 60 days before effective date of the disenrollment <p>and ends on the date that is 63 days after the effective date.</p> <p>Note: Proof of the effective date and the disenrollment date must accompany the application.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate
<p>Applicant dropped a Medicare supplement policy to join a Medicare Advantage Plan (or to switch to a Medicare Select policy) for the first time, and voluntarily disenrolls:</p> <ul style="list-style-type: none"> • within 12 months of joining the plan and wants to switch back to the Medicare Supplement plan. (Trial Right) 	<p>Begins on:</p> <ul style="list-style-type: none"> • 60 days before effective date of the disenrollment <p>and ends on the date that is 63 days after the effective date.</p> <p>Note: Proof of the effective date and the disenrollment date must accompany the application.</p>	<p>Applicant may:</p> <p>re-enroll in the Medicare supplement policy from the same carrier without answering health questions if that plan is available for new sales; or if that plan is no longer available from that carrier, the individual can enroll without answering health questions in:</p> <p>MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue)

Event that triggers Guaranteed Issue Rights Qualifying Criteria	Medicare Supplement Guaranteed Issue Time Period	Plans Available <i>without</i> answering health questions
		<ul style="list-style-type: none"> • Plan D preferred premium rate • Plan F preferred premium rate • Plan F-High Deductible preferred premium rate • Plan N preferred premium rate

Conversion Rights from Other Wellmark Coverage

Qualifying Criteria	Conversion Time Period	Plans Available <i>without</i> answering health questions
<p>Applicant age 65 or older and enrolled in Medicare Parts A and B also has coverage through a Wellmark employer group (other than employer group retiree coverage that provides benefits secondary to Medicare). For example, applicant has been actively employed (TEFRA¹) or the dependent of an active employee (DEFRA²).</p>	<p>Application must be signed within 31 days of applicant terminating group coverage.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D standard premium rate • Plan F standard premium rate • Plan F-High Deductible standard premium rate • Plan N standard premium rate
<p>Applicant has coverage through a Wellmark Under 65 Individual policy since prior to turning age 65 and is enrolled in Medicare Parts A and B.</p>	<p>Application must be signed within 31 days of applicant terminating individual coverage.</p>	<p>All MedicareBlue SupplementSM plans:</p> <ul style="list-style-type: none"> • Plan A (guaranteed issue) • Plan D standard premium rate • Plan F standard premium rate • Plan F-High Deductible standard premium rate • Plan N standard premium rate

¹ Tax Equity and Fiscal Responsibility Act of 1982

² Deficit Reduction Act

Qualified Medicare Beneficiary (QMB)

New applicants or existing plan members determined to be a Qualified Medicare Beneficiary (QMB) must be offered a prescription plan. See “[Subsidies for people who need extra help – MedicareBlue PPO](#)” (www.yourmedicareolutions.com> Learn > Q&A). If the new applicant or existing plan member applies during the open enrollment period, he/she will not have to answer health questions.

Documentation of Title XIX coverage from the Department of Human Services is required for anyone qualified as a QMB in order to process the Senior Blue application.

Other Coverage/Duplication of Benefits

If a new applicant has other coverage in force on the proposed effective date that would duplicate benefits provided by the MedicareBlue SupplementSM coverage, he/she must indicate this duplication on the application in Section G, “Answer the following questions about your past and current coverage.” The applicant must also indicate the name of the company and the type of policy in force.

- If a new applicant has another Medicare supplement coverage in force, he/she is **not** eligible for MedicareBlue SupplementSM *unless* he/she intends to replace the in-force coverage with a MedicareBlue SupplementSM policy.
- If an applicant applies outside the six-month open enrollment period, he/she must answer health questions unless the applicant is applying for MedicareBlue SupplementSM (guaranteed issue) Plan A.
- Spouses must be enrolled on separate Medicare supplement policies.
- If applying through Farm Bureau, the applicant must be a Farm Bureau member. (Only one Farm Bureau membership is required for each applicant and spouse.)
- Applicants covered under Medicaid medical benefits can be approved as long as coverage under Title XIX does not duplicate MedicareBlue SupplementSM coverage.
- If an applicant is enrolled in Medicare Advantage, the applicant is not eligible for a Medicare supplement policy unless the effective date is on or after termination of the applicant’s Medicare Advantage coverage.

Suspension of Coverage Available During Medicaid Eligibility

A member may request a suspension of coverage of the period (not to exceed twenty-four (24) months) in which the member has applied for and has been determined entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). The member

must notify Wellmark within 90 days after the date the member has become entitled to such assistance and must provide Wellmark with a copy of his/her “Notice of Decision” letter from Medicaid. Wellmark suspends the Medicare supplement coverage effective the date the member became eligible for medical assistance. Wellmark will refund premiums paid, subject to adjustment for paid claims.

If a suspension occurs and the member loses entitlement to Medicaid assistance within 24 months, the policy or, if that policy is no longer available, a substantially equivalent policy may be reinstated as of the date the entitlement is terminated. If the Medicare supplement policy provided coverage for outpatient prescription drugs and the plan member enrolled in Medicare Part D while the policy was suspended, the reinstated policy will not have prescription drug coverage. The member must notify Wellmark within 90 days after the date of such a loss and must provide Wellmark with a copy of Medicaid’s notice that he/she is losing entitlement. The member is responsible to pay premiums effective as of the date of the termination of Medicaid entitlement. (The reinstatement effective date would be retroactive to the first of the month in which Title XIX entitlement is lost, provided notification is made within 90 days of such loss.)

Suspension of Coverage During Enrollment in Group Health Plan

Members may request a suspension of coverage for the period in which they are entitled to Medicare benefits as the result of a disability and are enrolled in a group health plan sponsored by their current or former employer or employee organization. The member must notify Wellmark within 90 days of being notified of entitlement or of becoming entitled to such assistance, whichever is later. Wellmark will return any portion of the premium paid by the member which is attributed to the period of the other coverage, subject to adjustment for paid claims.

If a suspension occurs and the member loses entitlement to the other coverage, the member’s policy or, if that is no longer available, a substantially equivalent policy will be reinstated automatically as of the date the member’s coverage is terminated if the member notifies Wellmark that he/she lost the other coverage. If the Medicare supplement policy provided coverage for outpatient prescription drugs and the member enrolled in Medicare Part D while the policy was suspended, the reinstated policy will not have outpatient prescription drug coverage. The member must notify Wellmark within 90 days after the date of such a loss.

Description for Marketable Products

MedicareBlue SupplementSM

MedicareBlue SupplementSM policies supplement Medicare Parts A and B coverage. The Medicare Program partially covers hospital, medical, and surgical services.

MedicareBlue SupplementSM plans pay some or all coinsurance amounts and may provide coverage for Medicare deductibles and additional benefits.

There are five MedicareBlue SupplementSM plans available for new sales and for changes to existing policies:

- MedicareBlue SupplementSM (guaranteed issue) Plan A
- MedicareBlue SupplementSM Plan D
- MedicareBlue SupplementSM Plan F
- MedicareBlue SupplementSM Plan F-High Deductible
- MedicareBlue SupplementSM Plan N

Please refer to the MedicareBlue Supplement plan Outline of Coverage and/or policy for a complete description of benefits and for specific policy details.

Products No Longer Available for New Sales or Plan Changes

Senior Blue Plan J is not available for effective dates of January 1, 2006, and after. Any member enrolled in Plan J with effective dates prior to January 1, 2006, may continue coverage as long as he or she is not enrolled in Medicare Part D.

Senior Blue Select Plans C and F were closed to new enrollment effective January 1, 2008.

Senior Blue Plans A (guaranteed issue) and **C** (guaranteed issue) and **C, E, F, and L** are closed to new enrollment effective June 1, 2010. Existing Senior Blue members may keep their policies in force.

Existing plan members must answer health questions if they are transferring from “old” Protection Plus Plans (Basic I, II or III) to MedicareBlue SupplementSM Plans D, F, F-High Deductible, and N. Existing members of Senior Blue Plans (A, C, E, F, J, or L) must answer health questions if they are transferring to MedicareBlue SupplementSM Plans D, F, F-High Deductible, or N.

Limitations of Medicare Supplement Policies

Senior Blue/ MedicareBlue SupplementSM policies do *not* supplement Medicare Advantage plans and do not pay benefits when an individual is enrolled in a Medicare Advantage plan. (**Please note:** If already enrolled in a Medicare Advantage plan, the member *may not* purchase Medicare Supplement unless the effective date of the Medicare Supplement coverage is on or after the termination date of the Medicare Advantage plan coverage. See [Eligibility: Other Coverage/Duplication of Benefits](#) above.) Iowa law does not require Medicare Supplement carriers to refund premium if the member cancels his/her Medicare Supplement policy during the policy year.

Residency Requirements

To issue a Medicare supplement policy, new applicants or existing members must be a resident of Iowa. *Members residing outside the state of Iowa are not eligible to apply.*

Exception: If an Iowa resident lives near the state border and has been assigned an out-of-state address or post office box in a neighboring state, the applicant may apply by attaching one of the following as proof of residency:

- Copy of a valid Iowa driver's license;
- Iowa voter's registration card; or
- Copy of an Iowa income tax return for the most recent tax year.

Solicitation Restrictions

Agents may begin submitting applications 120 days before the new applicant's or existing plan member's 65th birthday (but no sooner).

Application Scenarios (Eligibility Checklist)

Health
Questions
Required?

	Yes	No
New applicant, enrolled in Medicare Parts A and B and age 65 applies for:		
• Any MedicareBlue Supplement SM plan during the six-month open enrollment period.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
• MedicareBlue Supplement SM Guaranteed Issue Plan A outside of the six-month open enrollment period.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
• MedicareBlue Supplement SM Plan D, F, F-High Deductible or N outside of the six-month open enrollment period.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
New applicant who is enrolled in Medicare Parts A and B due to a disability and under age 65 applies for:		
• MedicareBlue Supplement SM Guaranteed Issue Plan A.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
• MedicareBlue Supplement SM Plan D, F, F-High Deductible or N.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Applicant whose group retiree benefit plan/program from any carrier, including Wellmark, is involuntarily terminated or changed to provide lesser benefits or whose network changes causing the retiree to reside outside of the plan's service area, applies within 63 days of termination or change of the group coverage (proof of loss or change is required):		
• MedicareBlue Supplement SM Plan A, D, F, F-High Deductible or N.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Enrollee in Medicare Advantage, Medicare Risk or Cost, or Medicare Select Plan with any carrier and is involuntarily terminated, applies within 63 days after the date the applicable coverage is terminated (proof of loss is required):		
• MedicareBlue Supplement SM Plan A, D, F, F-High Deductible, or N.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Applicant enrolled in Medicare Advantage, Medicare Risk or Cost, PACE, or Medicare Select Plan with any carrier upon first becoming enrolled in Medicare Part B at age 65 or older, disenrolls in first 12 months, applies within 63 days of the effective date of disenrollment (proof required):		
• MedicareBlue Supplement SM Plan A, D, F, or F-High Deductible, or N.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Applicant under age 65 enrolled in Medicare Advantage, Medicare Risk or Cost, PACE, or Medicare Select Plan with any carrier upon first becoming enrolled in Medicare Part B due to a disability and disenrolls in first 12 months:		
• MedicareBlue Supplement SM Guaranteed Issue Plan A. (not eligible for any other plan)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Applicant enrolled in Medicare Supplement, subsequently enrolls in Medicare Advantage, Medicare Risk or Cost, PACE, or Medicare Select Plan with any carrier, disenrolls in first 12 months, applies within 63 days of the effective date of disenrollment (proof required):		
• MedicareBlue Supplement SM Plan most recently enrolled in.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
• MedicareBlue Supplement SM Plan A, D, F, F-High Deductible. or N if original Medicare Supplement policy is no longer available from original carrier.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Application Scenarios (Eligibility Checklist)

Health
Questions
Required?
Yes No

Existing member aged 65 or older, enrolled under a Wellmark group coverage (other than group retiree coverage that provides benefits secondary to Medicare) that ends, is enrolled in Medicare Parts A and B, living in Iowa, and applying within 31 days of termination of group coverage:

MedicareBlue SupplementSM Plan A, D, F, F-High Deductible or N.

Yes No

Existing member transfers from “old” Protection Plus Plans Basic I, II, or III to:

- MedicareBlue SupplementSM Guaranteed Issue Plan A.
- MedicareBlue SupplementSM Plans D, F, F-High Deductible, and N.

Yes No
 Yes No

New applicant or existing member under or over age 65, qualifying as a Qualified Medicare Beneficiary (QMB), applies:

- During the six-month open enrollment period. **Note:** QMB must apply for Medicare Part D.
- Outside of the six-month open enrollment period. **Note:** QMB must apply for Medicare Part D.

Yes No
 Yes No

Field Underwriting Process

The application is field underwritten by the agent to determine if the applicant will be:

- * accepted under guarantee issue rights or offered a guaranteed issue plan only, or
- * offered a plan at standard premium rates, or
- * offered a plan at preferred premium rates.

(Individual Enrollment Processing Unit makes the final determination if application and all attachments are complete.)

Condition Amendments

Condition amendments are not issued on MedicareBlue SupplementSM policies.

Waiting Periods

There are **no** waiting periods for preexisting conditions.

Answering Health Questions

When answering health questions in sections D and/or E of the Application for MedicareBlue Supplement (M-53314), please note the following:

- If one or more questions are checked “yes” in Section D of the Application for MedicareBlue Supplement (M-53314), the new applicant or existing member may *only* choose MedicareBlue SupplementSM (guaranteed issue) Plan A.
- If one or more health conditions in Section E of the Application for MedicareBlue Supplement (M-53314) are checked, the new applicant or existing member is eligible for MedicareBlue SupplementSM Plans A, D, F, F-High Deductible, and N at the standard rate.
- If all questions are answered “no” in Sections D and E of the Application for MedicareBlue Supplement (M-53314), the applicant is eligible for MedicareBlue SupplementSM Plans D, F, F-High Deductible, and N at the preferred rate.

Right to Return the Policy

The plan member has the *right to return* the policy if dissatisfied for any reason. Notification to cancel the policy as never effective must be sent to Wellmark within 30 days of the member’s receipt of the policy and ID cards. This cancellation will result in a refund of any paid premiums.

Membership Information

Effective Dates

While the preferred effective date is the 1st or 15th of the month (unless other Medicare Supplement coverage is in effect that terminates on a date that would cause a duplication of coverage), other dates are acceptable as follows:

- An agent may assign the effective date within 120 days following the application signature date.
- The effective date **must** be the same as or later than the Medicare Part B effective date. **Note:** If applicant's birthday is on the first day of the month, Part B will start the first day of the prior month. (*For example*, if birthday is May 1, applicant's effective date will be April 1.)
- The effective date may be any day of the month following the signature date on the application. For example:

If an application is signed on October 23, an acceptable effective date is any day from October 24 onward.

If an applicant requests a first of the month effective date, the effective date would be the first of the month following the signature date on the application.

If an effective date is not specified on the application, a first of the month effective date is assigned.

Note: If the applicant does not wish to have a lapse in coverage, he/she must sign the application before the termination date of the other coverage. However, the effective date may not begin before the termination date of the other Medicare Supplement coverage.

- The effective date for increasing or changing benefits would be the first of the month following the signature date on the application. *Wellmark cannot honor retroactive requests.*
- If no effective date is written on the application, the first of the month following the signature date on the application will be assigned.
- The effective date for a disabled plan member under age 65 who is enrolled in Medicare Parts A and B may be the same as or later than his/her Medicare effective date. If a plan member fails to notify Wellmark within 31 days of the enrollment in Medicare, the effective date may be based on Wellmark's notification date. Claims history for the individual may affect the effective date assigned.

Figuring Premiums

Premiums for new sales are calculated using factors for attained-age and gender. Additionally, a factor for tobacco use is included for persons enrolling outside of an open enrollment period. To figure premium for an effective date other than the first of the month, take the monthly premium amount stated on the Rate Sheet (based on the applicant's age on the proposed effective date and gender--and tobacco use if enrolling outside of a Medicare Supplement Open Enrollment or Guaranteed Issue Rights period) and multiply it by the factor corresponding to the effective date of coverage.

For example, if the premium is \$59.50 per month and the effective date of coverage is the 10th of the month, you would multiply \$59.50 x .7000 to determine the amount to pay (\$41.65) for coverage from the 10th through the end of the month. You will need to add the monthly premium to establish the amount to be submitted with the application. In our example: \$59.50 + 41.65 = \$101.15.

Odd Effective Date Factor Table

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

Payment

Modes

Two modes of payment are available:

- Direct Billed
- Automatic Clearing House (ACH)

The automatic premium withdrawal will change periodically to correspond with the applicable premium and service fee. The authorization for automatic premium withdrawals includes authorization for automatic withdrawal of any changed amount unless the member calls or provides his/her bank with written notice not less than three business days before a scheduled withdrawal to stop the payment. If the member calls his/her bank to stop payment, the member may be required to provide a written request within 14 days after that call. The member will be responsible for any fee assessed by his/her bank for stop-payment orders that the member makes.

If a member wishes to cancel ACH withdrawal with Wellmark and change to direct bill, Wellmark must receive his/her written notification at least 20 days before the member's next scheduled withdrawal.

If a member is unable to make his/her scheduled direct billed payment or if there will not be enough funds in the account for an ACH payment, the member may make a credit card payment by phone. Such credit card payments do not change the member's mode of payment for any future payments.

A member choosing this option may call NCO at 1-800-968-1305. NCO will validate the member's identity, credit card number, expiration date, and amount of payment. Service fees may be applied.

The member will need to allow time for Wellmark to receive payment notification. Insufficient funds procedures do apply if the credit card payment is not posted prior to the end of the direct bill due date grace period or the ACH draft date.

Frequencies

Four frequencies are available:

- Monthly ACH – a monthly premium would be for the first day of a month through the last day of such month. (Monthly direct billed allowed for hardship cases only.)

Note: If hardship is indicated, a brief explanation must accompany the application. **Hardship is defined as poverty level.**

- Quarterly – a quarterly payment would be for any calendar quarterly period.

- Semi-Annual – a semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31.
- Annual – an annual premium would be for January 1 through December 31 of the applicable year.

Payer Not Listed on Application

Attach “[Automatic Payment Authorization Form](#)” M-5779 if the payer is not present to sign the application.

ACH Requests

If ACH is requested:

- First or fifth of the month withdrawal is available.
- Checking or savings account withdrawals are allowed.

If checking is indicated, attach a preprinted voided check.

- Wellmark will prorate the initial bill so future premium due dates will be either the first or fifth of the month for ACH. If direct billed quarterly, semi-annual or annual frequencies are elected, future premium due dates will be on the first of the month.

Completing the Application

Guidelines

What to Attach to the Application

- ACH request (if applicable). Form [M-5779](#), along with a preprinted voided check, must be included when payer is not present to sign the application.
- Notice of guaranteed issue rights from prior insurer if applicable.

Where to Send the Application

Applications and supporting documents should be forwarded *within 15 days* of the signature date. They may be faxed to 515-376-9045 or mailed to:

Wellmark Blue Cross Blue Shield of Iowa
Station 3W190
P.O. Box 14527
Des Moines, Iowa 50306-3527

Scanned applications and supporting documents may be e-mailed to INDMEMMAIN@wellmark.com.

Once an application is processed, a welcome letter, identification cards, a policy, and a copy of the application will be sent to the plan member.

MedicareBlue SupplementSM Application Key

General Information

- Write legibly (printing is advised). ***Ink is required.*** *Do not use pencil.*
- Complete every item in each section. If something does not apply, write “N/A.”

A. Tell us about yourself.

- Enter the desired effective date.
- Complete name, date of birth, gender, Social Security number, phone number, and address of applicant.
- Answer “yes” or “no” to the Farm Bureau Member question, and provide information if “yes.”
- Answer “yes” or “no” to tobacco use question. (Not required if applying within an open enrollment period.)

Tobacco use question **not** used for rating when member:

- n open enrolls during the Medicare Supplement Open Enrollment six-month period which begins the month the member is both age 65 or older and enrolled for benefits under Medicare Part B, *or*
- n enrolls due to an event that makes him/her eligible for Guaranteed Issue Rights.

Tobacco use question **is** used for rating when an existing member moves:

- n from a prestandardized or standardized plan to a modernized plan, answering health questions, *or*
 - n to a plan by completing an application and answering health questions, resulting in a plan with increased benefits, *or*
 - n to a plan by completing an application **WITHOUT** answering health questions, resulting in a plan with decreased benefits.
- Answer “yes” or “no” to reinstatement question.
 - Include other payer billing information, if applicable.

B. Provide us with your Medicare information

- Copy the Medicare number and Part A and Part B effective dates from the applicant's Medicare card.

C. Answer the following questions to determine if your acceptance is guaranteed.

- Indicate if the applicant has turned age 65 in the last 6 months.
- Indicate if the applicant has enrolled in Medicare Part B in the last 6 months. If yes, include the Part B effective date.

D. Answer the following health questions to determine what plans you are eligible for.

- See also these sections elsewhere in this *Guide* for additional information about when health questions are required and when they are not:
 - [Application Scenarios](#)
 - [Increasing Benefits for Existing Senior Blue/Senior Blue Select/MedicareBlue SupplementSM Plan Members](#)
 - Decreasing Benefits [Decreasing Benefits for Existing Senior Blue/MedicareBlue SupplementSM Plan Members](#)
 - [Existing Blue Plan Transfers](#)

E. Answer the following health questions to determine if you qualify for preferred rating.

- Complete this section only if applicant answered “no” to all questions in Section D.

Health Questions – Definitions for Conditions listed in Sections D and E

- **Acquired Immune Deficiency Syndrome (AIDS or tested positive for HIV):** The stage of HIV disease in which a person's immune system is suppressed and therefore susceptible to infections and tumors. A person diagnosed as infected with HIV (human immunodeficiency virus)
- **Alcohol Abuse or Alcoholism:** Excessive use of alcohol which leads to physical, emotional, social, or legal problems. Also known as ETOH (ethyl alcohol or ethanol) or alcohol dependence.
- **Alzheimer's Disease/Dementia/Cognitive Disorders:** Disorders of memory or orientation of time/person/place; intermittent or worsening confusion. Alzheimer's Disease is the most common form of dementia.
- **Amputation Due to Disease:** A diseased arm or leg removed by surgery.
- **Amyotrophic Lateral Sclerosis (ALS):** A degeneration of motor neuron cells that causes a dysfunction or weakness in one part of the body that gradually spreads. Also known as Lou Gehrig Disease.
- **Aneurysm:** An abnormal widening or bulging in the wall of an artery or blood vessel.
- **Anorexia Nervosa:** See [eating disorder](#).
- **Artery Blockage:** A hardening or narrowing of the arteries. Same as Arteriosclerosis or Atherosclerosis.
- **Atrial Fibrillation or Atrial Flutter:** A heart rhythm disorder that causes the upper atrial chambers of the heart to beat in an abnormal way. Atrial fibrillation is rapid and irregular. Atrial Flutter is rapid and regular beats.
- **Bipolar or Manic Depressive:** A mental disorder in which a person experiences mood changes from very-high energy (manic) to extreme lows of depression.
- **Bone Marrow Transplant:** A surgical procedure in which defective or cancerous bone marrow is replaced with healthy bone marrow, either from the patient (autotransplant) or from a donor (allogeneic transplant).
- **Bronchiectasis:** A chronic inflammatory or degenerative condition of one or more bronchi or bronchioles marked by dilatation and loss of elasticity of the walls.
- **Cancer (other than skin):** A malignant growth caused when cells multiply uncontrollably. Some types of cancer include carcinoma, lymphoma, leukemia, myeloma, neoplasm, or sarcoma.
- **Cardiomyopathy:** A weakening of the heart muscle wall, leading to congestive heart failure and abnormal cardiac rhythm. .

- **Carotid Artery Disease:** The main arteries in the neck—supplying blood to the brain—become blocked or narrowed.
- **Chronic Asthma:** Recurring episodes of airway obstruction or bronchospasm accompanied by wheezing and coughing and by a sense of constriction in the chest. The disease may be caused by certain triggers such as allergy exposure, exercise, or viral infections.
- **Chronic Bronchitis:** See [Bronchiectasis](#).
- **Chronic Interstitial Lung Disease:** Chronic lung disease affecting primarily the lung tissue that, when severe, can cause coughing and worsening shortness of breath—which may lead to having to use supplemental oxygen.
- **Chronic Obstructive Pulmonary Disease (COPD):**
Most cases are caused by exposure to noxious stimuli such as cigarette smoke causing an inflammatory response in the lung. Chronic Bronchitis occurs with mucous gland inflammation and thickening of the bronchial walls. Emphysema occurs when the alveolar air sacs are damaged with airway narrowing. Both diseases cause shortness of breath with exertion, coughing, and wheezing with limitation of lung function that can progress rapidly.
- **Chronic Pancreatitis:** Recurring or ongoing inflammation of the pancreas that may lead to scarring and loss of function.
- **Chronic Pulmonary Fibrosis:**
A disease that causes chronic progressive alveolar scarring and damage leading to worsening shortness of breath and high risk of mortality.
- **Chronic Renal Failure (CRF) or Insufficiency (CRI):** A chronic loss of the ability of the kidneys to function and remove waste from the blood. Factors that may cause renal injury are many, such as uncontrolled high blood pressure or diabetes. Treatment requires identification of the underlying cause and if severely affected, may lead to peritoneal or hemodialysis, or a person might require a kidney transplant.
- **Cirrhosis:** Widespread disruption of normal liver structure by fibrosis and the formation of regenerative nodules that is caused by any of various chronic progressive conditions affecting the liver from factors such as long-term alcohol abuse or chronic hepatitis.
- **Congestive Heart Failure:** Weakness of the heart muscle, causing decreased blood flow and a build-up of fluid in the lungs and body tissues. Also known as congestive heart disease, left heart failure, or right heart failure.
- **Deep Vein Thrombosis/Blood Clot in Vein:** A condition marked by the formation of a clot within a deep vein (as of the leg or pelvis) that may be asymptomatic or be accompanied by symptoms (as swelling and pain) and that is potentially life threatening if dislodgment of the thrombus results in pulmonary embolism—abbreviation *DVT*.

- **Diabetes (with complications such as: Neuropathy/nerve damage, Kidney Disease, or Retinopathy) or require an insulin pump:** A disorder of insulin in the body that leads to high blood sugar.
- **Drug Abuse or Use of Illegal Drugs:** Any medically unnecessary use of prescription, over the counter, or illegal drug(s) for non-therapeutic or non-medical reasons to obtain a high or euphoric state.
- **Eating Disorder:** Anorexia, bulimia, binge eating or other disorder characterized by disturbances in eating behavior.
- **Emphysema:** See [Chronic Obstructive Pulmonary Disease \(COPD\)](#).
- **Esophageal Varices:** Veins in the esophagus that become wider and are fragile that can often result in bleeding from the esophagus.
- **Heart Attack:** Occurs when the blood supply to part of the heart is interrupted, causing damage to the heart muscle. Also know as Myocardial infarction (MI).
- **Hemiplegia:** Inability to move one side of the body, typically associated with a stroke.
- **Hemophilia:** A sex-linked hereditary blood defect that occurs almost exclusively in males and is characterized by delayed clotting of the blood and consequent difficulty in controlling bleeding even after minor injuries.
- **Hepatitis:** a disease or condition marked by inflammation of the liver (as hepatitis A, hepatitis B-- called also *serum hepatitis*, or hepatitis C-- usually transmitted by infected blood or blood products).
- **Internal Organ or Blood Cancer:** A malignant growth caused when cells multiply uncontrollably in internal organs or in the bone marrow.
- **Kidney/Renal Disease: Chronic Renal Failure:** The final stage of kidney failure (e.g., resulting from diabetes, chronic hypertension, or glomerulonephritis) that is marked by the complete or nearly complete irreversible loss of renal function—called also end-stage kidney disease, end-stage kidney failure, end-stage renal failure.
- **Leukemia:** A blood or bone marrow cancer causing abnormal blood cell production (usually white blood cells). Also known as AML, ALL, CML, or CLL.
- **Liver Problems:** [Cirrhosis](#) or [Hepatitis B or C](#)
- **Lymphoma:** An immune system cancer that often starts in the lymph nodes as a malignant tumor. Also known as non-Hodgkin's Lymphoma (NHL) or Hodgkin's (HL).
- **Major Depression Disorder:** a mood disorder that is characterized by a loss of interest or pleasure in almost all activities for an extended time period and can be associated with disturbances of appetite, sleep, a decrease in energy, or difficulties in thinking or making decisions. Depression is often associated with chronic medical conditions that can lead to worsening medical outcomes.

- **Melanoma:** A malignant tumor caused by uncontrolled growth of pigment cells, usually originating in the skin or eye(s).
- **Multiple Sclerosis:** A disease affecting the brain and spinal cord, sometimes progressing to physical and mental disability. Also known as MS.
- **Myasthenia Gravis:** A disease affecting the ability of the muscle to contract, leading to progressive weakness.
- **Organ Transplant:** A surgical procedure in which a damaged or failing organ is replaced with a healthy organ from a donor.
- **Osteoporosis with Fracture:** a condition that affects especially older women and is characterized by loss of bone mass which can lead to broken bones or vertebra.
- **Paraplegia:** Inability to move the lower portion of the body and both legs.
- **Quadriplegia:** Inability to move both arms and both legs.
- **Parkinson's Disease:** A neurological disorder that results in symptoms such as trembling, abnormal movement of the hands, mask-like face, trouble walking, falls, or swallowing difficulty.
- **Peripheral Artery Disease:** Includes all conditions involving poor blood flow to the arms, hands, legs, or feet. Also known as PVD and peripheral artery disease (PAD).
- **Polycystic Kidney Disease:** An inherited disorder in which multiple cysts form in or on the kidneys, causing them to enlarge. Also known as PKD or PCKD.
- **Renal Artery Stenosis:** A blockage or narrowing of the artery supplying blood to the kidney.
- **Retinopathy:** Any of various non-inflammatory disorders of the retina including some that cause blindness (such as diabetic retinopathy).
- **Rheumatoid Arthritis (RA):** A disorder in which the immune system attacks the body's joints and/or organs. Also known as RA.
- **Sarcoidosis:** A chronic disease of unknown cause that is characterized by the formation of nodules in the lymph nodes, lungs, bones, and skin.
- **Schizophrenia:** A mental disorder in which it is difficult for a person to tell the difference between real and unreal experiences, to think logically, to have normal emotional responses to others, and to behave normally in social situations.
- **Scleroderma:** A progressive disorder leading to hardening of the connective tissue of any organ including the skin, heart, esophagus, kidney, and lungs.
- **Seizure Disorders:** Epilepsy/Seizure/Convulsions. Seizures of any kind.
- **Spinal Stenosis:** A narrowing of the spinal canal, putting pressure on the spinal cord and nerves.

- **Stroke/Transient Ischemic Attack (TIA):** Loss of blood flow to an area of the brain, which may result in the sudden onset of permanent (stroke) or temporary (TIA) symptoms. Also known as cerebrovascular accident (CVA).
- **Systemic Lupus Erythematosus (SLE):** A chronic inflammatory disease that can affect every organ system in the body due to a dysfunctional immune system generating autoantibodies (cells that attack one's own body). Also known as SLE.

F. Choose the plan you are applying for.

- Indicate benefit plan desired.

G. Answer the following questions about your past and current coverage.

- Indicate if the applicant is eligible for medical assistance through the state Medicaid program.
- Determine whether the applicant has current coverage with any Medicare plan other than original Medicare including, for example, a Medicare Advantage plan or a Medicare HMO or PPO. If "yes," answer the additional questions and complete the "Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage Insurance," form on last page of application.
- Indicate whether applicant has current coverage with any other Medicare supplement plan. If "yes," indicate the name of the company. Indicate whether the prior policy is being replaced. If "yes," also complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage," form # on last page of application.
- Indicate whether applicant has any other health insurance in force that would duplicate coverage. If "yes," indicate the name of the company and type of policy.

H. Choose your method of payment.

- Applicant can choose any effective date of the month, based on the termination date of his/her other health insurance coverage. However, Wellmark will prorate the initial bill so that future premium due dates will be either the first or the fifth of the month, if monthly ACH. (**Note:** The member's first bill may be more than a single month's premium.)
- If premium payment withdrawal is rejected because of insufficient funds in the member's account, future Wellmark ACH withdrawals may be more than a single month's premium.
- If quarterly or semi-annual modes of payment are elected, future premium due dates will be the first of the month.

Applicant Signature and Agreement and Certification

Signature acknowledges receipt of a “MedicareBlue SupplementSM Outline of Coverage” and “Guide to Health Insurance for People with Medicare.” The agent must ensure that the applicant, legal guardian or Power of Attorney (POA) signs and dates the application. The *signature must* be that of the applicant (*printing is not acceptable*). The agent must also include his/her agent number--and sign if submitting a paper application. .

- List any policies you have sold the applicant in the last 5 years in the **For Agent Only** section.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

- Complete this page if applicant is intending to terminate existing Medicare supplement or Medicare Advantage insurance.
- This page replaces form M-53106.

Membership Changes

Change Requests

How to Submit Changes

Submit changes in address, mode of payment, name change, Farm Bureau member numbers, notice of death or requests for a policy cancellation on either of the following:

- The “[Direct Pay Information Change Request](#)” (form N-5707).
- A letter from the plan member including their signature.

Note: Address changes may be submitted by contacting Customer Service.

Request to Cancel

A request to cancel a policy must be signed by the plan member, legal guardian, or Power of Attorney (POA). Unless the POA has already been placed on file with Wellmark, the POA must be included with the request. This request (if not submitted on the “Direct Pay Information Change Request” form) must indicate the name of the plan member to be cancelled and his/her ID number.

The cancellation date will be the first of the month following Wellmark Blue Cross and Blue Shield’s receipt of the request to cancel. A refund will be made, if applicable.

Cancellations due to the death of a plan member are effective the day after death. Notification of the cancellations due to death will be accepted from the plan member’s family, agent/broker, legal guardian or POA. A refund will be made. If the refund is to be sent to an address other than that of the deceased plan member, the address change must be requested by the Executor of the Estate.

Wellmark’s Cancellation Policy

Coverage will end if any of the following occurs:

- The policy is used fraudulently or the member fraudulently misrepresents or concealed material facts in the application. If this happens, Wellmark will recover any claim payments made minus any premiums paid.
- The member fails to pay the monthly premium by the end of the grace period.

Cancellation dates will be:

- When the member fails to pay the monthly premium, a termination notice will be produced 31 days following the due date and the plan will be retroactively canceled.
- Wellmark will cancel the policy effective on the first of the month following receipt of the request.
- Wellmark will honor retroactive cancellation requests when members are moving to Wellmark's Medicare PPO plan.

Reinstatement for Nonpayment

Plan members who pay through Automatic Clearing House (ACH) electronic funds transfer are subject to the following guidelines:

- If canceled for nonpayment, two reinstatements will be allowed for nonpayment of premium per 12-month period.
- If canceled for nonpayment, Wellmark Membership and Enrollment will forward a letter to the plan member requesting appropriate premium payment within 31 calendar days.
- If a plan member requests cancellation and subsequently requests reinstatement, the policy can be reinstated only if the request is received within 10 days of the cancellation process date or prior to the cancellation date.
- Once the plan is terminated, the plan member must complete a new application and may not be able to have the same Medicare supplement plan as prior to the cancellation.
- A plan member wishing to reinstate coverage must send a reinstatement request and payment to Wellmark within 31 days of the date of the termination notice.

Plan members who are direct billed are subject to the following guidelines:

- A final pay notice will be forwarded when a payment is more than 15 days past due.
- A termination notice will be produced 31 days following the due date, and the plan will be retroactively canceled.
- A plan member wishing to reinstate must send a reinstatement request and payment to Wellmark within 31 days of the termination notice.
- Two reinstatements will be permitted within a 12-month period.
- If the plan is terminated for the third time, the plan member must complete a new application and may not be able to have the same Medicare supplement plan as prior to the cancellation.

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

Benefit Changes

Any change in benefits must be submitted on an application.

Increasing Benefits for Existing Senior Blue/ MedicareBlue SupplementSM Plan Members

A current Senior Blue or MedicareBlue SupplementSM plan member *within* the six-month guaranteed open enrollment period may increase benefits *without answering health questions*. The change in benefits will be effective the first of the month following the signature date on the application.

A current member who is outside the six-month guaranteed open enrollment period or a guarantee issue rights period must answer health questions to increase benefits.

If an underwritten application for increased benefits is not accepted, the plan member's current level of benefits will continue.

Please see the chart below to determine if health questions are required when moving from a Senior Blue plan to a MedicareBlue SupplementSM plan at a time other than during open enrollment. **Note:** Changes to existing Medicare Supplement policies can only be made with an effective date on the first of the month.

Senior Blue Plan	Health Questions Required	NO Health Questions
Plan A	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Guaranteed Issue Plan C	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Underwritten Plan C	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or Plan N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Plan E	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or Plan N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Plan F	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or Plan N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Plan J	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or Plan N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Plan L	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or N	MedicareBlue Supplement SM Guaranteed Issue Plan A
Pre-Standardized plans	MedicareBlue Supplement SM Plans D, F, F-High Deductible, or N	MedicareBlue Supplement SM Guaranteed Issue Plan A

Please see the chart below to determine if health questions are required when moving from one MedicareBlue SupplementSM plan to another at a time other than during open enrollment or guaranteed issue situations.

MedicareBlue Supplement SM Plan	Health Questions Required	NO Health Questions
Plan A	Plans D, F, F-High Deductible or N	N/A
Plan D	Plan F	Plans A, F-High Deductible or N
Plan F	N/A	Plans A, D, F-High Deductible or N
Plan F-High Deductible	Plans D, F (if criteria below are NOT met) or N	Plan A, F (if criteria below are met)
Plan N	Plans D or F	Plans A, F-High Deductible

Criteria for moving from Plan F-High Deductible to Plan F with NO health questions:

- Allowed only during the Annual Coordinated Election Period (ACEP) established by Medicare. In 2011, this time period will be Saturday, Oct. 15, through Wednesday, Dec. 7. Application must have a signature date between Oct. 15 and Dec. 7, 2011. Application must be received by Wellmark no later than Thursday, Dec. 22, 2011.
- Member must be enrolled in high-deductible Plan F for a minimum of 12 months' continuous coverage before he/she is eligible to change to Plan F during the annual election period. (**Note:** A member on high-deductible Plan F effective January 1, 2011, may apply during the ACEP to move to Plan F with an effective date of January 1, 2012.)
- Effective date for Plan F under this provision is January 1 of the year following the annual election period (i.e., for 2011, Plan F effective for those moving from Plan F-High Deductible will be Jan. 1, 2012).

Decreasing Benefits for Existing Senior Blue/ MedicareBlue SupplementSM Plan Members

Health questions are not required to decrease benefits. All decreases are made effective the first of the month following the signature date on the application.

Note: Members may *not* move to a lesser-benefit plan within a product that is no longer being sold—for example, although a member may stay on his/her Senior Blue Plan F, he/she may not move to a Senior Blue Plan C. See also "[Products No Longer Available for New Sales of Plan Changes](#)" section above.

Existing Blue Plan Transfers

Member Transfers Between Plans

Current plan members enrolled in Senior Blue or MedicareBlue SupplementSM who relocate outside of Iowa are **not** required to transfer to the Blue Cross Blue Shield plan in the state where they reside. However, members may **not** change plans after moving out of Iowa because any plan change would require that the member be a resident of Iowa.

A Medicare supplement member from another Blue Cross Blue Shield Plan who moves to Iowa is not required to transfer to an Iowa plan.

If the member does wish to transfer, he/she may choose an equivalent standardized plan without answering health questions if he/she is outside the guaranteed enrollment period—for example, Plan D to Plan D. If Wellmark does not offer the transferring member's plan, the member may choose a Wellmark-offered plan with lesser benefits without answering health questions—for example, a transferring member who has Plan G would be offered MedicareBlue SupplementSM Plan D, N, F-high deductible, or A.

Standardized/modernized Plan benefit hierarchy from most to least is as follows: **F → G → C → D → N → M → L → K → F-high deductible → B → A.**

For purposes of this hierarchy, a prestandardized plan is equal to the modernized plan of the same letter. For example, a prestandardized Plan F will be considered the equivalent of a modernized Plan F, and the modernized Plan F would be offered without requiring the member to answer health questions.

Member Transfers Within Plan

If Farm Bureau notifies Wellmark the plan member has not paid his/her Farm Bureau dues, Wellmark will transfer the plan member to the equivalent MedicareBlue Supplement Plan under Direct Pay—for example, a Farm Bureau Plan F to a direct pay Plan F. An application is not required as long as the benefits do not change. New ID cards and policies are not issued when benefits remain the same. A member who lives out of state will still be transferred from Farm Bureau to an equivalent Iowa direct pay plan—which is not considered a plan change (any plan change requires that the member be a resident of Iowa).

Forms

Access forms on www.wellmark.com > Brokers > Sales Toolkit > Medicare > Forms.

Glossary

ACH: Automatic Clearing House is used for all automatic withdrawals.

Applicant: The person who seeks to contract for insurance benefits.

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

Employer Sponsored Group Plan: Any plan, fund, or program which is established or maintained by an employer for the purpose of providing its participants or their beneficiaries--through the purchase of insurance or otherwise--medical, surgical, or hospital care or benefits.

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

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

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

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

Medicare Advantage Plan: A Medicare managed program under which a non-governmental entity arranges for all Medicare-covered services, including physicians, labs, and hospitals. Some Medicare Advantage plans may offer the Medicare prescription drug benefits to their enrollees.

Medicare Supplement Policy: A policy that is primarily a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Plan Member: The person who signs for a policy and is eligible to receive the benefits.

Agent of Record

Individual Business

Note: For complete and updated Agent of Record information, please refer to the Iowa Agency Manual found on www.wellmark.com > Brokers tab/Broker Secure Home > Resources-Agency/Agent Resources > Agency Manuals.

Disclaimer: To the extent that any statement in this section is inconsistent with any provision in the Agency Manual, the Agency Manual will control.

Wellmark Blue Cross and Blue Shield of Iowa is obligated by contractual agreement to pay new and renewal commissions to the original writing Agency as long as the Agency agreement and the policy are in force. A request to transfer the designated Agent of Record (AOR) for any existing brokered individual policy from one Agency to another Agency will be considered if the customer submits an AOR Transfer Request – Individual Policy (Form AOR-2) and one of the following conditions or reasons occurs, as determined in Wellmark’s sole and absolute discretion:

- Acts of fraud or customer abuse;
- Agency, Agent or customer misrepresentation;
- The current Agent of Record no longer has an Agency Agreement with Wellmark; or
- Any other reason that Wellmark decides, in its sole and absolute discretion, is an adequate basis for changing the AOR designation on an individual policy from one Agency to another Agency.

The AOR for an individual policy may be transferred from one Agency to another Agency without the submission of an AOR Transfer Request – Individual Policy (Form AOR-2) if the individual’s type of individual policy changes for one of the following reasons or if there is a break in the individual’s Wellmark coverage of at least thirty (30) days, in which case the AOR will be determined by the application accepted by Wellmark for the new individual policy:

- Submission of an under age 65 application (requiring answering of health questions) that results in a change of health plan (WHPI or WBCBSI), contract holder or pool of business;
- The member changes from an Under 65 coverage to Medicare Supplement or Medicare Advantage coverage;
- The member moves from Wellmark Medicare Supplement to MedicareBlue PPO;
- The member moves from MedicareBlue PPO to Wellmark Medicare Supplement;

- The member moves from or to Short Term Major Medical coverage from or to another individual coverage.

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

An agent desiring to make an Agent of Record change must submit the request through the agent's Wellmark-authorized agency.

A customer may also submit a request to convert a customer's brokered individual policy to a Wellmark direct business individual policy at any time.

Wellmark will not accept any request that any Wellmark individual policy currently assigned to a Wellmark Employed Sales Staff member ("Wellmark Direct Business") be transferred to an Agency and that the transferee Agency be designated as the AOR for the policy.

Agent's Notes