

Expect more from your retirement.

When it comes to retirement, there are many decisions to consider. But, when it comes to your retiree health insurance, you should know that you have coverage options. Nyemaster Goode, P.C. is proud to offer you a retiree health insurance program from Wellmark Blue Cross and Blue Shield of Iowa. Your 2026 monthly premium for Program F is \$262.20.

Get more!

Through your employer-sponsored retiree health insurance program, you will get more than just standard Medicare supplement benefits. You get coverage from a company you trust, plus extra programs and services just for you, like:

- **Nationwide coverage.** Visit any Medicare-participating provider across the country with your coverage.
- **Fitness discounts.** Get access to special discounts on fitness memberships, heart rate monitors, healthy eating plans and more. Explore your options online at [Wellmark.com/Blue365](https://www.wellmark.com/Blue365).
- **A local and knowledgeable staff.** Contact a highly trained customer service representative to get the personalized support you need.
- **BlueSM e-newsletter.** Sign up to receive the monthly *Blue* e-newsletter at [Wellmark.com/Blue/Subscribe](https://www.wellmark.com/Blue/Subscribe) for important information you need to know about your health coverage. It also features tips for staying active, member stories and so much more.

Next steps

Take time to learn about your coverage options so you can feel confident in making your decision.

1. Review the program details, like what Medicare pays, what your health coverage will pay and what you can expect to pay.
2. Mail in your application using the enclosed business reply envelope.
3. Expect to receive some important documents in the mail including a letter confirming your enrollment, a new Wellmark ID card and a coverage manual.

Have questions? We can help!

If you have questions contact the Medicare Business team at medicarebusinesssteam@wellmark.com.

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

Blue365® is a discount program available to members who have medical coverage with Wellmark. This is not insurance. Blue365® is a registered mark of the Blue Cross and Blue Shield Association.



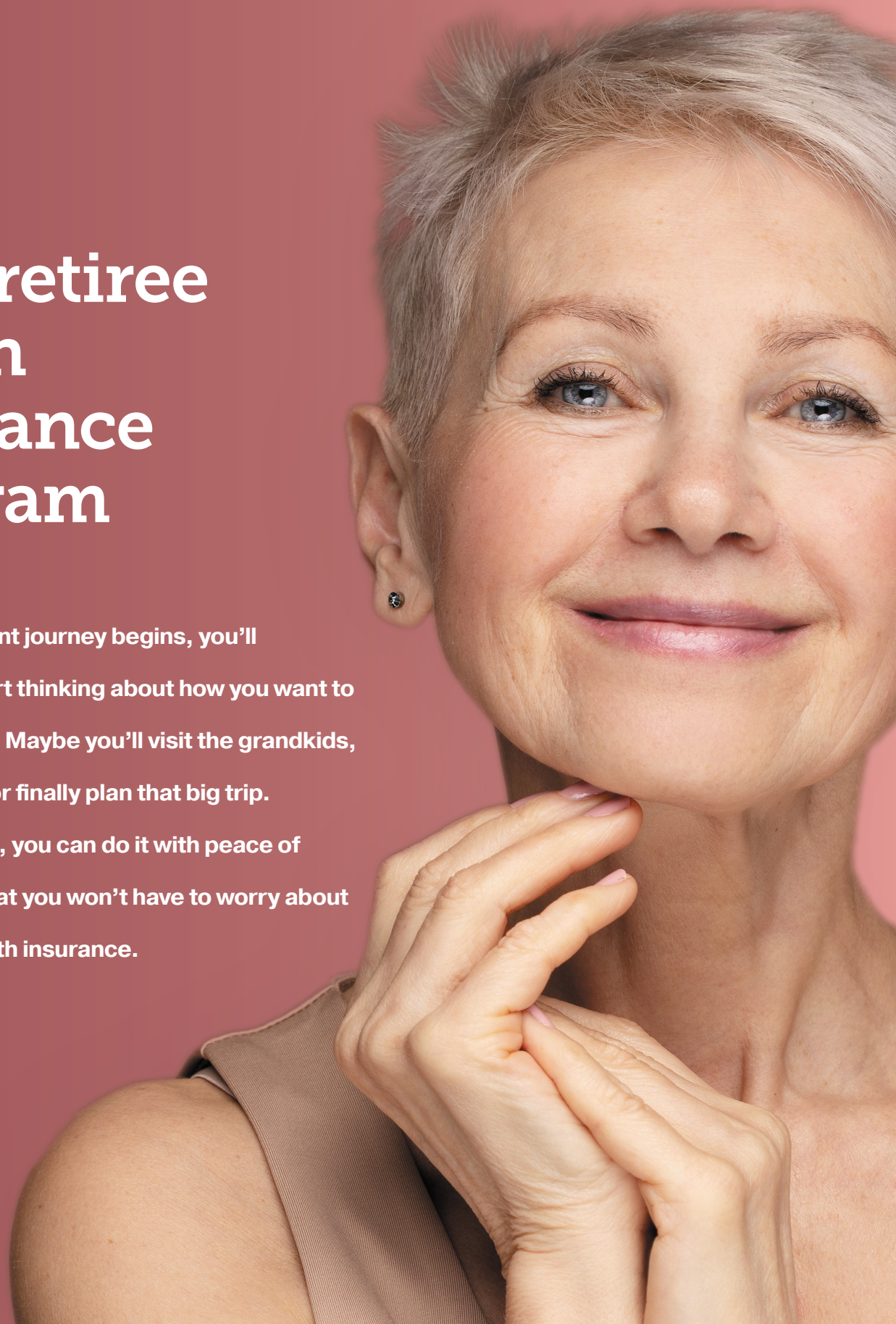
Your guide to your
retiree health insurance program



Your retiree health insurance program

As your retirement journey begins, you'll undoubtedly start thinking about how you want to spend your time. Maybe you'll visit the grandkids, volunteer more or finally plan that big trip.

Whatever you do, you can do it with peace of mind knowing that you won't have to worry about your retiree health insurance.



Wellmark's Retiree Health Insurance program helps pay for health care costs and some services not covered by Medicare, such as deductibles, copays and coinsurance.

What to expect

Medicare provides basic protection against the high cost of health care, but it will not pay for all your medical expenses. That's why your employer is offering you the option to enroll in this Wellmark Blue Cross and Blue Shield coverage in addition to Medicare. The retiree health insurance program is designed to help you pay for some hospital, medical and surgical services that are only partially covered by Medicare.

Please see the enclosed plan overview sheet for a more detailed explanation of the benefits.

How Medicare works

To understand how your retiree health insurance plan works, you need to understand how Original Medicare works. Original Medicare has two parts:

1. **Medicare Part A covers hospital care**, including home health and hospice care. It is offered at no cost to nearly everyone eligible for Medicare.
2. **Medicare Part B covers medical care**, which includes doctor visits, outpatient care and supplies. It is available for a monthly premium to most people eligible for Medicare.

To be eligible to enroll in a Wellmark Retiree Health Insurance program, you must:

- Be enrolled in Medicare Part A.
- Be enrolled in Medicare Part B.
- Continue to pay your Part A (when applicable) and B premiums.

Medicare IRMAA — Income-Related Monthly Adjustment Amount

In addition to the regular monthly premium, higher-income individuals may pay an additional premium surcharge for Medicare Parts B and D.

To determine whether IRMAA may apply to you, contact the Social Security Administration.

Original Medicare **enrollment**

There are different times when you can enroll in Original Medicare, and each of those times has certain rules around applying and when your coverage will begin.

When you are first eligible for Medicare, you have seven months to sign up. This is called your Initial Enrollment Period (IEP). The period begins three months before you turn 65, goes throughout your birthday month and three months after you turn 65. Coverage can start as early as the month of your 65th birthday (or the month before if your birthday is on the first of the month).

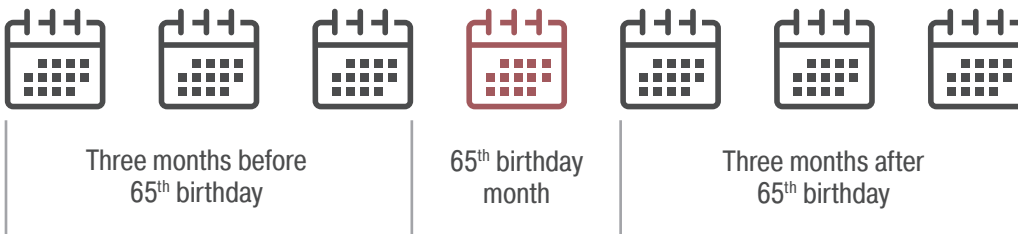
- **Most people are automatically enrolled in hospital coverage (Part A)** on the first day of the month they turn 65. If you don't receive an enrollment notice three months before your 65th birthday, call Social Security.
- **You can sign up for medical coverage (Part B)** during your IEP. If you already have other health insurance (for example, if you're still working and your employer provides your coverage) you can delay your enrollment

without a penalty. But be careful, if you delay your enrollment and do not have other health insurance, the Centers for Medicare & Medicaid Services will charge you a penalty once you do sign up. And you will pay that penalty for as long as you're enrolled.

If you miss this period, you will have a chance to enroll in Medicare again during the General Enrollment Period, which takes place every year between Jan. 1 and March 31, with coverage starting the month after you sign up. But if you wait, you may have to pay more. So, it's in your best interest to understand how your current coverage works with Medicare before making any decisions.

Once you are enrolled, Social Security will send you a "Welcome to Medicare" packet that includes your Medicare card.

Initial Enrollment Period





**There are three ways to apply
for Medicare Parts A and B.**

1. ONLINE

Visit the Social Security website.

2. BY PHONE

Call the Social Security national
customer hotline at 800-772-1213.

3. IN PERSON

Visit your local Social Security office.



Retiree health insurance enrollment

Let us put our knowledge and experience to work for you. Once you've reviewed your retiree health plan information, all you have to do is enroll.

Wellmark will take care of the rest.

To enroll:

1. Make sure you meet the requirements. You must be enrolled in Medicare Parts A and B before you enroll. Because this plan is offered by your employer, they may have additional guidelines.
2. Complete the application enclosed in this information packet.
3. Mail in your application using the enclosed business reply envelope. The envelope is pre-addressed and the postage has been paid. All you have to do is drop it in a mailbox.

If your employer is offering additional coverage to you, like prescription drug plans, they'll have more enrollment instructions.

Your employer's human resources department will have more information about:

- When your coverage will begin.
- When your application is due.
- When you can expect plan or premium changes.
- Any additional coverage options that may be available to you.
- Who to contact with questions.

Check your mail!

Once you enroll, you'll receive some important documents in the mail. Here's what you can expect two to three weeks after you submit your application:

- A letter confirming your enrollment.
- A new Wellmark ID card — make sure you show your insurance card when using your benefits.
- A coverage manual — keep this document so you can reference it later.

Prescription drug plans that **work for you**

Now that you've learned more about Original Medicare and your coverage options, you know drug costs are not covered. A prescription drug plan is a small price to pay for help in protecting against unexpected drug costs that can quickly add up.

If you enroll in a prescription drug plan, you will pay a monthly premium plus a share of the cost of your prescriptions. Drug plans vary by types of drugs covered, how much you pay and the pharmacy you use.

When to enroll

If your employer does not sponsor a group prescription drug plan, you can enroll in your own individual coverage during your IEP. If you don't enroll, the Centers for Medicare & Medicaid Services may charge you a penalty — in the form of a higher monthly Part D premium — when you enroll later. The longer you wait to enroll, the higher the penalty.

Switching plans

You can switch your prescription drug coverage during the Annual Enrollment Period (AEP), which runs every year from Oct. 15 through Dec. 7.

There are **Special Enrollment Periods** that may allow you to switch outside the AEP. Some examples include:

- You are eligible for financial help from Social Security.
- You move outside of your plan's service area.
- Your plan's government contract ends, or the plan goes out of business.
- You lose prescription drug coverage from an employer or union, or your drug coverage is no longer as good as the standard Part D benefit.
- The plan you're switching to was given a five-star rating by the Centers for Medicare & Medicaid Services.

Ask your employer's human resources department about prescription drug options available to you.



Avoid costly penalties

Don't delay when considering your options for prescription drug plans. The Centers for Medicare & Medicaid Services will charge you a penalty if you go 63 continuous days without drug coverage after your IEP.

The easiest way to avoid this penalty is to join a Medicare drug plan when you're first eligible.

Learn more at [Medicare.gov](https://www.medicare.gov).

Get more with **Wellmark**

With Wellmark, you get more than standard benefits. You get coverage from a company you trust and extra programs and services at no cost to you.

Coverage on-the-go

myWellmark® is a valuable online resource to help you make the most of your coverage. You can choose from a variety of tools, information and support to make the most of your coverage. Take advantage of these features at **myWellmark.com**.

Local and knowledgeable staff

You can trust the voice on the other end of the phone. We live and work in your community and have a highly trained staff with years of experience.

Exclusive discounts

Get access to special discounts on gym memberships, heart rate monitors, health eating plans and more with Blue365®. The program is free to members. Explore a variety of valuable discounts online at **Wellmark.com/Blue365**.

Information to live your healthiest life from BlueSM

Visit **Wellmark.com/Blue** to better understand your health plan benefits, and get nutrition information, ideas to help you stay active, member stories and much more. And, while you're there, subscribe to the Blue e-newsletter to get this information sent straight to your inbox every month.

Definitions

Benefit period — For Original Medicare, the benefit period begins on the first day of a hospital stay and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.

Centers for Medicare & Medicaid Services (CMS) — The federal government agency that runs Medicare and works with each state to run their Medicaid program.

Coinsurance — The percentage of the Medicare-approved amount you pay for a medical service. With some plans, you do not pay coinsurance until you have paid a deductible.

Copayment — A fixed amount you pay for each medical service, such as a doctor's visit. For example, a copayment might be \$20 for a doctor's visit and \$7 for a prescription drug you receive.

Cost sharing — The way Medicare and your health plan share your health care costs with you. Deductibles, coinsurance and copayments are all types of cost sharing.

Deductible — A set amount of money you must pay before your plan pays. Usually you have a separate deductible for Medicare Part A, Part B and Part D. Some deductibles are covered by retiree health insurance plans.

Eligible care — Medical care and services that qualify to be covered by your health plan.

Lifetime reserve days — These are extra days that Original Medicare will pay for when you are in a hospital for more than 90 days. You have 60 lifetime reserve days to use during your lifetime, with a per-day copayment when you use them.

Medigap (Medicare Supplement) plan — Health insurance policies that typically have standardized benefits and are sold by private insurance companies. Medigap policies work together with your Medicare Part A and Part B coverage. They generally allow you to go to any doctor or hospital that accepts Medicare.

Part D (prescription drug plan) — A Medicare Part D prescription drug plan may be a stand-alone plan that you can enroll in if you have Original Medicare and/or a Medicare Supplement plan.

Premium — A fixed amount you pay, usually paid each month, to be in a Medicare health plan or prescription drug plan.

Preventive care — Care that is provided to keep you healthy or find an illness or disease early, when it can be better treated. Examples of preventive care are flu shots, mammograms and screening for diabetes.

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم ٨٠٠-٥٢٤-٩٢٤٢ أو (خدمة الهاتف النصي: ٨٨٨-٧٨١-٤٢٦٢).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຜິດຕໍ່ຫົວ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyon tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တောင်းဆိုပါ—နမူနာတစ်ခုကို, ကိုတိတိမဟုတ်ဘဲတစ်ခုတည်း, လာဘ်ဘက်လက်ဘက်လဲ, ဆိုလျက်ရှိလိမ့်မည်။ ၈၀၀-၅၂၄-၉၂၄ ဖုန်းနံပါတ် (TTY: ၈၈၈-၇၈၁-၄၂၆) တွေ့ပါ။

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ አገዛዝ አገልግሎቶቻችን ከአፍሪካ ላይ የገናኙን፡፡ በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውለው ያነጋግሩን፡፡

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnaamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłtí'go níká bizaad bee áká' adoowoł, t'áá jiiik'é, náhóló. Kojí' hóline' 800-524-9242 doodaii' (TTY: 888-781-4262)



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Group Retiree Insurance Overview Program F

Medicare (Part A) Hospital Services PER BENEFIT PERIOD

Services		Medicare pays	Program F pays	You pay
Hospitalization¹ Semiprivate room and board, general nursing and miscellaneous services and supplies	First 60 days	All but \$1,736	\$1,736 (Part A deductible)	\$0
	Days 61-90	All but \$434 a day	\$434 a day	\$0
	Day 91 and after: • While using 60 lifetime reserve days	All but \$868 a day	\$868 a day	\$0
	• Once lifetime reserve days are used: –Additional 365 days	\$0	100% of Medicare eligible expenses ²	\$0
	–Beyond the additional 365 days	\$0	\$0	All costs
Skilled nursing facility care¹ You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	\$0	\$0
	Days 21-100	All but \$217 a day	Up to \$217 a day	\$0
	Day 101 and after	\$0	\$0	All costs
Blood	First 3 pints	\$0	3 pints	\$0
	Additional amounts	100%	\$0	\$0
Hospice care Available as long as your doctor certifies you are terminally ill and you elect to receive these services		All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

¹ A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

² When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Basic Benefits."

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available at [Medicare.gov](https://www.medicare.gov).

Medicare (Part B) Medical Services PER CALENDAR YEAR

Services		Medicare pays	Program F pays	You pay
Medical expenses IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First \$283 of Medicare- approved amounts ³	\$0	\$283 (Part B deductible)	\$0
	Remainder of Medicare- approved amounts	Generally 80%	Generally 20%	\$0
Part B excess charges (Above Medicare-Approved Amounts)		\$0	100%	\$0
Blood	First 3 pints	\$0	3 pints	\$0
	Next \$283 of Medicare- approved amounts ³	\$0	\$283 (Part B deductible)	\$0
	Remainder of Medicare- approved amounts	80%	20%	\$0
Clinical laboratory services BLOOD TESTS FOR DIAGNOSTIC SERVICES		100%	\$0	\$0

Medicare Parts A & B

Services		Medicare pays	Program F pays	You pay
Home health care MEDICARE-APPROVED SERVICES	Medically necessary skilled care services and medical supplies	100%	\$0	\$0
	Durable Medical Equipment: • First \$283 of Medicare- approved amounts ³	\$0	\$283 (Part B deductible)	\$0
	• Remainder of Medicare- approved amounts	80%	20%	\$0
Preventive medical care benefit COVERED BY MEDICARE Some annual physical and preventive tests and services administered by a participating provider who accepts Medicare.		100%	\$0	\$0

³ Once you have been billed \$283 of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Other benefits not covered by Medicare

Services		Medicare pays	Program F pays	You pay
Foreign travel NOT COVERED BY MEDICARE	Medically necessary emergency care services beginning during the first 60 days of each trip outside the United States <ul style="list-style-type: none"> • First \$250 each calendar year 	\$0	\$0	\$250
	<ul style="list-style-type: none"> • Remainder of charges 	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

Medicare benefits are subject to change.

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to the terms and conditions specified in the Benefits Certificate and enrollment regulations in force when the Benefits Certificate becomes effective. For complete details of Medicare benefits and exclusions, you may obtain a copy of *Medicare and You* from the Social Security Administration, or visit [Medicare.gov](https://www.medicare.gov).

**Need more information about the services covered by Medicare?
 Visit [Medicare.gov](https://www.medicare.gov) to learn more.**



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Dental plan details for Wellmark Medicare Supplement Members

Blue DentalSM plan details for effective dates on or after Jan. 1, 2026.

Cost details	Blue Dental 75 ¹	Blue Dental 100 ¹
Monthly premium	\$22.50	\$40.50
Benefit period deductible Diagnostic and preventive (check-ups and a teeth cleaning) services are not subject to deductible. Benefit period is based on the calendar year.	In-network you pay: \$75 Out-of-network you pay: \$150	In-network you pay: \$100 Out-of-network you pay: \$200
Benefit period maximum Benefit period is based on the calendar year.	\$1,000	\$1,000
Lifetime maximum	Lifetime maximum does NOT apply	Lifetime maximum does NOT apply
Diagnostic and preventive <ul style="list-style-type: none"> Preventive evaluation – check-ups Dental cleaning X-rays Periodontal maintenance therapy Space maintainers Fluoride treatments 	In-network plan pays: 80% Out-of-network plan pays: ² 60%	In-network plan pays: 100% Out-of-network plan pays: ² 60%
Basic restorative <ul style="list-style-type: none"> Cavity repair and tooth extraction Contour of bone Local anesthesia Routine oral surgery 	In-network plan pays: 50% Out-of-network plan pays: 40%	In-network plan pays: 80% Out-of-network plan pays: 60%
Endodontics <ul style="list-style-type: none"> Root canals Apicoectomy/periradicular surgery Direct pulp caps Pulpotomy Retrograde fillings Root canal therapy 	In-network plan pays: 50% Out-of-network plan pays: 40%	In-network plan pays: 50% Out-of-network plan pays: 30%
Periodontics <ul style="list-style-type: none"> Gum and bone disease treatment 	No coverage	In-network plan pays: 50% Out-of-network plan pays: 30%
Major restorative <ul style="list-style-type: none"> Crowns Onlays Inlays Posts and cores 	No coverage	In-network plan pays: 50% Out-of-network plan pays: 30%
Prosthodontics <ul style="list-style-type: none"> Crowns Dentures Bridges Partials 	No coverage	In-network plan pays: 50% Out-of-network plan pays: 30%
Benefit exclusion periods (also called waiting period) Full or partial credit is applied for any prior dental coverage without a lapse of more than 63 days.	Basic restorative – 6-month waiting period Endodontics – 12-month waiting period	Basic restorative – 6-month waiting period Endodontics, periodontics, major restorative, and prosthodontics – 12-month waiting period

¹ Blue Dental (Grid+) network

² Payment level for services provided by an out-of-network provider will be based on maximum allowable fee.

Plan details	Blue Dental 75 ¹	Blue Dental 100 ¹
Diagnostic and preventive dental services	<ul style="list-style-type: none"> Dental cleanings (prophylaxis) and oral evaluations are covered twice per benefit period. Periodontal maintenance therapy is available up to four treatments per benefit period. An additional dental cleaning (prophylaxis) or an extra periodontal maintenance procedure is available for diabetic members with the submission of a completed Extra Dental Cleaning Enrollment Form. Topical fluoride applications are covered. Sealant applications are covered once in a lifetime per permanent first and second molars. Bitewing X-Rays are covered once every 12 months.³ Full mouth X-Rays are covered once every five years. Occlusal, extraoral, and periapical X-rays are covered without a frequency limitation. Space maintainers are covered. 	<ul style="list-style-type: none"> Dental cleanings (prophylaxis) and oral evaluations are covered twice per benefit period. Periodontal maintenance therapy is available up to four treatments per benefit period. An additional dental cleaning (prophylaxis) or an extra periodontal maintenance procedure is available for diabetic members with the submission of a completed Extra Dental Cleaning Enrollment Form. Topical fluoride applications are covered. Sealant applications are covered once in a lifetime per permanent first and second molars. Bitewing X-Rays are covered once every 12 months.³ Full mouth X-Rays are covered once every five years. Occlusal, extraoral, and periapical X-Rays are covered without a frequency limitation. Space maintainers are covered.
Basic restorative	Cavity repair and tooth extractions are covered, including amalgam, silicate, acrylic and synthetic porcelain, and composite filling restorations. Posterior composites are limited to the allowance of a silver filling restoration. A six-month waiting period applies.	Cavity repair and tooth extraction services are covered, including amalgam, silicate, acrylic and synthetic porcelain, and composite filling restorations. Posterior composites are limited to the allowance of a silver filling restoration. A six-month waiting period applies.
Endodontics	Root canals and pulp treatments are covered. A 12-month waiting period applies.	Root canals and pulp treatments are covered. A 12-month waiting period applies.
Periodontics	Gum and bone disease treatment is NOT covered.	Gum and bone disease treatment is covered. Surgical periodontal procedures are covered once every three years for each quadrant. Non-surgical periodontal procedures are covered once every 24 months for each quadrant. A 12-month waiting period applies.
Major restorative	High-cost restorations are NOT covered.	Crowns, inlays and onlays are covered. Cast restorations for complicated tooth decay or fracture are covered once every five years beginning from date the cast restorations is cemented in place. Crowns limited to teeth that cannot be restored with a routine filling. A 12-month waiting period applies.
Prosthodontics	Dentures and bridges are NOT covered.	Dentures, bridges and implants are covered. Dentures (complete and partial) are covered once every five years. Denture relining is covered if performed six months or more after initial denture placement and limited to once every two years thereafter. Dental implants once in a lifetime per missing tooth. A 12-month waiting period applies.
Orthodontics	Orthodontics are NOT covered.	Orthodontics are NOT covered.
Pretreatment notification and estimate program	Pretreatment notification and estimate program applies to: <ul style="list-style-type: none"> Basic restorative (cavity repair and tooth extractions) Endodontics (root canals and pulp extractions) 	Pretreatment notification and estimate program applies to: <ul style="list-style-type: none"> Basic restorative (cavity repair and tooth extractions) Endodontics (root canals and pulp extractions) Periodontics (gum and bone disease) Major restorative (crowns, inlays, onlays) Prosthodontics (dentures, bridges, implants)

³ Based on the calendar year.

Call Wellmark customer service at 800-524-9242 with any questions.

Members will receive their dental ID card within two weeks of enrollment. Please read the benefits document for complete coverage details.



Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

Vision and hearing plan details for Wellmark Medicare Supplement Members

Avēsis vision and Amplifon hearing coverage plan details for effective dates on or after Jan. 1, 2026.

	Silver Vision & Hearing 100	Silver Vision & Hearing 130
Monthly premium	\$9.78	\$15.90
Eye exam	Covered in full after \$10 copay, every 12 months ¹ Out-of-network: up to \$35 Refraction: covered in full	Covered in full after \$10 copay, every 12 months ¹ Out-of-network: up to \$35 Refraction: covered in full
Materials copay (frames and spectacle lenses)	\$25	\$10
Frame	Covered once every 24 months, after materials copay up to \$100 retail allowance Out-of-network: up to \$25	Covered once every 24 months, after materials copay up to \$130 retail allowance Out-of-network: up to \$25
Standard plastic lenses	<ul style="list-style-type: none"> One pair covered in full after materials copay, every 12 months¹ Single vision, lined bifocal, lined trifocal, lenticular Progressive: \$50 retail allowance, plus 20% off² Specialty: corresponding standard lens reimbursement, plus 20% off² Out-of-network: standard plastic lenses up to \$25, lined bifocal up to \$40, lined trifocal up to \$50, lenticular up to \$80, progressives up to \$40 	<ul style="list-style-type: none"> One pair covered in full after materials copay, every 12 months¹ Single vision, lined bifocal, lined trifocal, lenticular Progressive: \$50 retail allowance, plus 20% off² Specialty: corresponding standard lens reimbursement, plus 20% off² Out-of-network: standard plastic lenses up to \$25, lined bifocal up to \$40, lined trifocal up to \$50, lenticular up to \$80, progressives up to \$40
Contact lenses	<ul style="list-style-type: none"> Covered up to allowance, every 12 months¹, in lieu of eyeglasses Conventional or disposable: \$110 allowance Contact lens allowance and evaluation, fitting and follow-up care (CLEFFU): not covered Medically necessary: covered in full Out-of-network: conventional or disposable up to \$80, medically necessary up to \$250 	<ul style="list-style-type: none"> Covered up to allowance, every 12 months¹, in lieu of eyeglasses Conventional or disposable: \$110 allowance Contact lens allowance and evaluation, fitting and follow-up care (CLEFFU): not covered Medically necessary: covered in full Out-of-network: conventional or disposable up to \$80, medically necessary up to \$250
Lens options	<ul style="list-style-type: none"> Up to 20% off Usual, Customary and Reasonable (UCR)³ Polycarbonate, scratch resistant coating, tint, ultraviolet protective coating (UV coating), all other lens options 	<ul style="list-style-type: none"> Up to 20% off Usual, Customary and Reasonable (UCR)³ Polycarbonate, scratch resistant coating, tint, ultraviolet protective coating (UV coating), all other lens options
Hearing test	In network: hearing screening ⁴ at no charge every 24 months Out-of-network: no coverage	In network: comprehensive hearing exam ⁵ covered up to \$48 every 24 months Out-of-network: up to \$48 reimbursement
Hearing device batteries / maintenance plan	One year of follow-up care Two years of free batteries (160 cells) Three-year loss and damage warranty	\$300 hearing device allowance per ear every five years ⁶ , plus discounts above the allowance One year of follow-up care Two years of free batteries (160 cells) Three-year loss and damage warranty
Benefit exclusion periods (also called waiting period)	Waiting periods do NOT apply	Waiting periods do NOT apply

¹ Based on the calendar year.

² Additional discounts are not insured benefits. Any specialty lenses or lens options ordered by the member are not funded by the benefit plan, and the member accepts sole financial responsibility for the order.

³ Certain retail chain locations do not offer further discounts.

⁴ Hearing screening: A pass/fail evaluation to determine if additional testing is needed.

⁵ Hearing exam: Comprehensive test to determine type and location of hearing loss.

⁶ This benefit period is based on five years after member receives a device, not the calendar year.

For more information, please call or visit:



(833) 554-1009
www.avesis.com



(888) 402-4716
www.amplifonusa.com/avesishearing

Members will receive their vision and hearing ID card within two weeks of enrollment.

Please read the benefits document for complete coverage details.

VISION LIMITATIONS AND EXCLUSIONS

Limitations — Fees charged by a Provider for services other than Vision Examination or covered Vision Materials must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under this Policy. Non-Preferred Provider expenses do not apply toward Preferred Provider expenses and Preferred Provider expenses do not apply toward Non-Preferred Provider expenses. Exclusions — No benefits will be paid for services or materials connected with or charges arising from: 1. orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2. medical and/or surgical treatment of the eye, eyes or supporting structures; 3. any eye or Vision Examination or any corrective eyewear, required by an Employer as a condition of employment and safety eyewear; 4. services provided as a result of any Workers' Compensation law, similar legislation or required by any governmental agency or program whether federal, state or subdivisions thereof; 5. Plano (non-prescription) lenses; 6. non-prescription sunglasses; or 7. two pair of glasses in lieu of bifocals. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Period when Vision Materials would next become available.

TERMINATION OF INSURANCE

This Policy will end on the earliest of the following dates:

1. the last day for which the required premium is not paid, subject to the Grace Period provision; 2. the date it is determined by a court of competent jurisdiction that an Insured Person has committed fraud against the Company; 3. any premium due date on or after the first Policy Anniversary Date. The Company will give at least a 31-day written notice of the Company's intent to non-renew; or 4. any date on or after the date the Company receives written notice of the Insured's intent to cancel.

HEARING BENEFIT PROVISIONS AND EXCLUSIONS

Hearing Examination Benefit — The Company will pay the benefit shown in the Schedule of Benefits for a Hearing Examination performed by a Physician or Audiologist to detect and diagnose Hearing Loss. Services must be received while the Insured's coverage under this Rider is in force.

Hearing Aid Benefit — The Company will pay the benefit shown in the Schedule of Benefits for a Hearing Aid prescribed by a Physician or Audiologist. The Hearing Aid must be ordered and received while the Insured's coverage under this Rider is in force.

Exclusions — In addition to the exclusions in the Policy, no benefits will be paid under this Rider for services or materials:

1. provided free of charge in the absence of insurance; 2. payable under any governmental plan or program whether Federal, state, or subdivisions thereof, except for medical assistance benefits under Title XIX of the Social Security Act (Medicaid); 3. for the medical and/or surgical treatment of the internal or external structures of the ear(s); 4. provided by a Hearing Aid Dispenser; 5. required by an employer as a condition of employment; 6. not prescribed by a Physician or Audiologist; 7. for Hearing Aid batteries, cleaning supplies, or accessories; 8. for ear protection devices or plugs; 9. for Assistive Listening Devices; or 10. for replacement due to loss, theft, of or damage to the Hearing Aid.



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Avēsis Vision is an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield products and services. Avēsis Vision is underwritten by Fidelity Security Life Insurance. Hearing Discount Savings Plan provided by Amplifon Hearing Health Care™. Amplifon Hearing Health Care is an independent company that does not provide Wellmark Blue Cross and Blue Shield products or services.