Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund

Summary Plan Description ("SPD")

Effective January 1, 2022

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Cedar Rapids Electrical Workers Local #405
Health and Welfare Fund
Summary Plan Description

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A. Your Plan Identification at a Glance

Plan Name:	Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund ("Plan")
Plan Sponsor and Plan Administrator:	Board of Trustees of the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund c/o Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401 319-398-3283, 6, ext. 1221
Names and Addresses of Trustees:	EMPLOYER TRUSTEES Ray Brown The ESCO Group 3450 3rd Avenue Marion, IA 52302 Ethan Domke Paulson Electric Company P.O. Box 1170 Cedar Rapids, IA 52406 Dave Murray Nelson Electric Company 618 14th Avenue SW Cedar Rapids, IA 52404 UNION TRUSTEES Jeffrey Cooling I.B.E.W. Local 405 1211 Wiley Boulevard S.W. Cedar Rapids, IA 52404 Junior Luensman I.B.E.W. Local 405 1211 Wiley Boulevard S.W. Cedar Rapids, IA 52404 Josh Umstead I.B.E.W. Local 405 1211 Wiley Boulevard S.W. Cedar Rapids, IA 52404
Employer ID Number:	23-7091120
Plan Number:	501
Plan Year:	January 1 through December 31
Plan Office and Administrative Manager	Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401 The Board of Trustees has contracted with Auxiant to serve as the Administrative Manager of the Plan. The Administrative Manager is responsible for collecting contributions, maintaining eligibility, keeping records and carrying out policy decisions made by the Board of Trustees.

A. Your Plan Identification at a Glance

Agent for Service of Legal Process	The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the following address: Board of Trustees of the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund c/o Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401 Service of legal process may also be made upon any Trustee.
Claims Administrator for Medical Benefits	Wellmark Blue Cross and Blue Shield of Iowa P.O. Box 9291 Des Moines, IA 50306
Prescription Benefit Manager	Wellmark Blue Cross and Blue Shield of Iowa 1331 Grand Avenue Des Moines, IA 50309-2901
Claims Administrator for HRA and Short Term Disability Benefits	Auxiant 424 1st Avenue NE Cedar Rapids, IA 52401
Claims Administrator for Dental Benefits	Delta Dental of Iowa P.O. Box 9000 Johnston, IA 50131-9000
Claims Administrator for Vision Benefits	Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401
Provider of Employee Assistance Benefits	Mercy Medical Center 701 10th Street SE Cedar Rapids, IA 52403
COBRA Administrator	Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401
Insurer of Life and Accidental Death and Dismemberment ("AD&D") Benefits	Union Labor Life Insurance Company 8403 Colesville Road Silver Spring, MD 20910

A. Your Plan Identification at a Glance

Type of Plan	This is a welfare benefit plan that provides medical, prescription drug, health reimbursement account ("HRA"), dental, vision, short term disability, employee assistance program ("EAP"), life insurance and accidental death and dismemberment ("AD&D") benefits.
Type of Administration	Contract and Insurer Administration
Plan Funding and Contributions	The Plan is funded through contributions made by Contributing Employers pursuant to a collective bargaining agreement, participation agreement or other written agreement and through contributions from Participants when self-paying. All Plan assets are maintained in the Trust Fund until such assets are used to pay for benefits. All Plan benefits are self-funded, except life insurance and AD&D benefits.
Collectively Bargained Plan	This group benefits plan is maintained pursuant to collective bargaining agreements ("CBAs"). Plan Participants and beneficiaries may obtain a copy of the applicable CBA and the names of the Contributing Employers participating in the Plan upon written request to the Administrative Manager. Copies of the CBAs are also available for examination by Participants and beneficiaries at the main I.B.E.W. Local 405 Union Office and at each employer establishment in which at least 50 Participants covered under the Plan are customarily working.

B. About This Summary Plan Description

1. **Governing Documents**

This summary plan description ("SPD") describes your rights and responsibilities under the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund ("Plan") and is intended to be a summary of the Plan's rules and regulations. You and your covered dependents have the right to request a copy of this SPD, at no cost to you, by contacting the Administrative Manager. You should familiarize yourself with the entire SPD because it describes your benefits, payment obligations, provider networks, claim processes, and other rights and responsibilities. This restatement of the SPD, effective January 1, 2022, replaces all prior versions of the SPD.

This SPD, together with the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund Plan Document, forms the master Plan Document, which is the Plan's controlling document.

2. **Interpreting this Summary Plan Description and the Master Plan Document**

The Board of Trustees is solely responsible for the management of the Plan and has the authority to control and manage the operation and administration of the Plan. Only the full Board of Trustees is authorized to interpret the terms of the Plan described in this SPD and will determine the answer to all questions that arise under it. The Trustees have the sole discretion to determine whether you meet the Plan's written eligibility requirements, or to interpret any other term in this SPD. Such interpretations and determinations will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a final decision of the Board of Trustees or its delegee is challenged in court, it is the intention of the parties that such decision will be upheld unless it is determined to be arbitrary or capricious.

No Contributing Employer, union, association or any agent, representative, officer or other person from a union, association or a Contributing Employer in such capacity, has the authority to interpret the Plan nor can any such person speak for the Board of Trustees or to act contrary to the written terms of the governing Plan documents. If you have any questions about your eligibility or benefits, contact the Administrative Manager, who is authorized by the Board of Trustees to answer certain questions. Matters that are not clear, or that need interpretation, will be referred to the Board of Trustees.

3. **Authority to Terminate, Amend, or Modify the Plan**

Only the Board of Trustees has the right, power and authority to terminate, amend, or modify the coverage described in this SPD at any time as may, in their discretion, be proper or necessary for the sound and efficient administration of the Plan, at any time, provided that such changes are not inconsistent with law. The Trustees intend that the terms of the Plan, including those relating to coverage and benefits, are legally enforceable while they are in effect. The right to change or eliminate any and all aspects of benefits provided to Participants and their dependents is a right specifically reserved to the Trustees. No amendment of the Plan will cause any part of the Trust Fund to be used or diverted for purposes other than for the benefit of Participants or their beneficiaries covered by the Plan.

Notices of any amendment to or modification of this SPD will be in writing and will be provided to each Participant within the time required by applicable regulations; such written notice will be as binding as this SPD. Please note that some changes may take effect before you are notified of such changes. This document does not describe changes to the Plan that occur after this SPD is printed.

4. **Release of Information**

As a condition of your participation in the Plan, you agree to release any necessary information requested about you so your claims can be processed for benefits.

You must allow any provider, facility, or their employee to give the Plan information about a treatment or condition. If the information requested is not received, or if you withhold information in your application for coverage or benefits, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application for coverage or benefits, then your coverage may be terminated under the Plan.

5. **Non-Assignment**
Neither you nor any of your dependents may, in any manner, alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber (collectively, for the purposes of this section, "assign") any right available due to coverage under the Plan, whether legal, equitable, or otherwise, including but not limited to any right to request documents or institute any court proceeding. In addition, neither you nor any of your dependents may assign benefits payable under the Plan. Any such attempted assignment to another person or entity (such as a facility in which you or your dependent are receiving or will receive care, a provider of medical services or supplies in consideration for medical services or supplies provided or to be provided, or any other person or entity that may have provided or paid for or agreed to provide or pay for any covered expense under the Plan will be null and void, and unenforceable. However, you may request that benefits due to you be paid directly to a such a provider (see *Other Benefit Payment Provisions*).

6. **Governing Law**
All questions pertaining to the validity and construction of the Plan's Trust Agreement, Plan Document, and the acts and transactions of the Trustees or of any matter affecting the Plan will be determined under federal law where applicable federal law exists; including the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). To the extent not preempted by federal law, this Plan will be governed by the law of the State of Iowa.

7. **Legal Action**
You cannot start any legal action against the Plan or the Trustees unless you have exhausted the applicable claims and appeals procedures and the external review process completely, as described in the *Claim and Appeal Procedures* section of this SPD.

You cannot bring any legal or equitable action against the Plan or the Trustees because of a claim under the Plan, or because of the alleged breach of the Plan provisions, more than two years after the end of the calendar year in which the Plan provides an adverse appeal determination.

8. **Statements**
Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act, and may be subject to prosecution. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

9. **Miscellaneous**
Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan. Charts included in this SPD provide a quick reference or summary but are not a complete description of all details about a benefit. A particular chart may not describe some significant factors that would help determine your coverage, payments, or other responsibilities. You should review details included in the SPD and should not rely only on an included chart. It is also important to follow any references to other sections of the SPD (references tell you to "see" a section or subject heading, such as, "see *Eligibility and Participation* section"). Pronouns used in this SPD include both masculine

and feminine gender unless the context indicates otherwise. Likewise, words used will be construed as though they were in the plural or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of this Plan.

C. Your Rights Under ERISA

1. **Employee Retirement Income Security Act of 1974 (ERISA)**
   Your rights concerning your coverage may be protected by ERISA, a federal law protecting your rights under this benefits plan. Any employee benefits plan established or maintained by an employer or employee organization or both is subject to this federal law unless the benefits plan is a governmental or church plan as defined in ERISA.

   As a Participant in this group welfare plan, you are entitled to certain rights and protections under ERISA.

2. **Receive Information About Your Plan and Benefits**
   You may examine, without charge, at the Plan Office or at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and participation agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

   You may obtain, upon written request to the Plan Office, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and participation agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Administrative Manager may make a reasonable charge for the copies.

   You may also obtain a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

3. **Continued Group Health Plan Coverage**
   You have the right to continue health care coverage for yourself, your Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. For more information on the rules governing your COBRA continuation coverage rights, review this SPD and the documents governing the Plan.

4. **Prudent Actions by Plan Fiduciaries**
   In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of employee benefits plans. The people who operate the Plan, called *fiduciaries* of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

5. **Enforcement of Rights**
   If your claim for a covered benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

   Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a

domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

6. **Assistance With Your Questions**

If you have any questions about the Plan, you should contact the Administrative Manager. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Office, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor,* listed in the telephone directory, or write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the *Employee Benefits Security Administration* (866-444-EBSA (3272)). You may also review EBSA's contact information through the Web at "http://askebsa.dol.gov" or "http://www.dol.gov/agencies/ebsa."

Section II

Eligibility and Participation

A. Eligibility - Bargaining Unit Employees
B. Eligibility - Non-Bargaining Unit Employees
C. Eligibility – Dependents
D. Rules for Dual Eligibility
E. Coverage Change and Termination Events
F. Continuation of Coverage Events

A. Eligibility - Bargaining Unit Employees

If you work under the jurisdiction of I.B.E.W. Local 405 and your Employer contributes to the Plan on your behalf (a "Contributing Employer") based on the number of hours you work as required under a collective bargaining agreement (covered employment), you are referred to in this SPD as a "Bargaining Unit Employee," and you are eligible to participate in this group health plan, following the waiting period set forth below.

All references to an "Employee" in this Section II.A. refer to Bargaining Unit Employees, unless noted otherwise.

1. **Contributions and Your Health Reimbursement Account ("HRA") / Dollar Bank**
   Contributions made by a Contributing Employer on your behalf, pursuant to a collective bargaining agreement or other written agreement, will be credited to your HRA. The balance of your HRA will be reduced by the monthly benefit plan premium charge, as determined by the Trustees, due for your benefits under the Plan. Any contribution amounts remaining after your monthly benefit plan premium charge is paid will remain in your HRA and will accumulate for future use, as allowed by the Plan. HRA funds are also available to reimburse medical, dental and vision expenses that are not reimbursable from other sources. See the *HRA Benefits* section of this SPD.

   If you participated in the Plan prior to January 1, 2008, contributions may have been deposited into an account referred to as the Dollar Bank, and you may have an existing balance in the Dollar Bank. The Dollar Bank has been considered "frozen" (*i.e.*, no new contributions are deposited) since January 1, 2008. The Dollar Bank is not a savings account that you own or that you can withdraw cash from. Participants with remaining balances that accumulated in the Dollar Bank can only be applied to maintain eligibility for coverage under the Plan. Any Dollar Bank balance you may have can be used only if your HRA has insufficient funds to cover your monthly benefit plan premium charge in order to maintain eligibility under the Plan.

2. **Initial Eligibility**
   Once an Employee meets the service requirement, the Employee will gain initial eligibility to participate in the Plan. The service requirement is satisfied upon the Employee's completion of 304 hours of work in covered employment within a 12-month period. The Employee's coverage under the Plan will begin on the first day of the third month after satisfying the service requirement, as shown in the following chart, provided the Employee submits an enrollment form within 365 days of the first day of that third month:

Month A Hours Worked	**Month B** Contributions Paid	**Month C** Administrative Processing	**Month D** Coverage Begins on 1st
Employee meets the 304 hour service requirement	Contributing Employer reports and contributes to the Plan for Employee's hours worked for Month A to the Administrative Manager	Administrative Manager sends a monthly statement to the Employee reflecting contributions to the Plan for the hours worked by the Employee in Month A	The Employee's (now a Plan Participant) coverage under the Plan begins on the first day of this month, provided he or she submits an enrollment form within 365 days

Example: If an Employee satisfied the 304-hour service requirement in January and submitted an enrollment form, coverage under the Plan would begin April 1st.

If the Employee does not submit an enrollment form by the deadline, his or her coverage under the Plan will begin on the first day of the month following completion of the form.

Eligibility after the first month of coverage under the Plan (*i.e.*, Month D) will be determined under the Continuation of Eligibility rules, set forth below.

3. **Enrollment – Plan Coverage Options**

There are two Plan coverage options: Orange Plan and Yellow Plan. The default Plan coverage option is the Orange Plan; you will be enrolled in the Orange Plan option for the remainder of the Plan Year in which you initially become eligible for coverage under the Plan, unless you file an enrollment form with the Administrative Manager requesting enrollment in the Yellow Plan option in advance of becoming eligible.

You may elect to change the Plan coverage option in which you are enrolled during the next annual enrollment period; the change will take effect at the beginning of the following Plan Year (January 1). If you do not elect to make a change during the annual enrollment period, you will remain enrolled in the Plan coverage option in which you are currently enrolled.

4. **Continuation of Eligibility**

(a) **Employer Contributions**

Once you meet the initial eligibility requirements set forth above, your eligibility to participate in the Plan will continue by deducting the monthly benefit plan premium charge, as determined by the Trustees, from your HRA, for as long as you are actively working, or available for work, in covered employment with a Contributing Employer that contributes to the Plan on your behalf. Contributions for hours worked in a month are required to be paid to the Plan by 15th day of the following month.

Example: Eligibility for coverage under the Plan in the month of April will be determined based on contributions paid to the Plan in February for hours worked in January.

(b) **Continuation of Eligibility without Employer Contributions**

In general, you may continue to be covered under the Plan so long as you have sufficient funds in your HRA (or Dollar Bank, if applicable) to cover your monthly benefit plan premium charge. There are exceptions to this rule, as explained below. If the general rule applies, coverage under the Plan will terminate at the end of the coverage month in which your HRA balance (and Dollar Bank balance, if applicable) is insufficient to cover the next month's benefit plan premium charge. For example, if your HRA balance (and Dollar Bank balance, if applicable) is insufficient to cover your monthly benefit plan premium charge for the month of April, and no other rules apply to continue your eligibility, your coverage under the Plan will terminate at the end of March.

A Participant's HRA (and Dollar Bank, if applicable) will be reduced to a zero balance at the end of the month when:

(i) A Participant stops working for a Contributing Employer when work in covered employment is otherwise available; or

(ii) A Participant goes to work for an employer in the electrical industry that is not signatory to a collective bargaining agreement with an I.B.E.W. local union.

(c) **Self-Payment Contributions**
After becoming initially eligible for coverage under the Plan, you may be allowed to make self-payment contributions if you are in danger of losing eligibility due to a period of unemployment. To be eligible to make self-payments, you must be available for work in covered employment with a Contributing Employer that participates in the Plan.

A Participant's self-payment contribution must be equal to his or her monthly benefit plan premium charge, reduced by any existing HRA balance (and Dollar Bank balance, if any). Self-payments must be received by the Administrative Manager by the 28th of the month before the month of coverage for which the payment is due. **All notices will be sent to the last known address on file with the Administrative Manager so it is important that any address changes are reported to the Administrative Manager immediately.** Continued eligibility by means of self-payments can be continued for a maximum of 18 successive months of coverage following exhaustion of the Participant's HRA balance (and Dollar Bank balance, if any). However, if the electrical industry is suffering from an extended period of widespread unemployment, the Trustees may temporarily allow self-payment contributions for more than 18 successive months of coverage. The maximum number of self-payment contributions does not apply to Participants who are Totally Disabled (see subsection (d) below).

Once the Participant reaches the maximum number of self-payment contributions, COBRA continuation coverage may apply. See the *COBRA Continuation Coverage* section of this SPD for more information.

When a Participant maintains eligibility by making self-payments, the Participant and his or her eligible dependents retain the same benefits and all normal Plan provisions apply.

(d) **Continuation of Eligibility during Total Disability by Self-Payment Contributions**
If a Participant is Totally Disabled while he or she is eligible to participate in the Plan, but is not eligible for Medicare, his or her eligibility may be continued after exhaustion of his or her HRA (and Dollar Bank, if applicable), even if the Participant has made the maximum number of normal self-payment contributions. Such a Participant may continue eligibility for coverage under the Plan by means of self-payment contributions at a rate equivalent to 50% of that which normally applies to persons available for active employment until the earlier of:

(i) The date the Participant is no longer Totally Disabled; or

(ii) The date the Participant becomes eligible for Medicare or a state sponsored Medicaid program.

In the event such Totally Disabled Participant becomes eligible to receive Medicare or Medicaid due to Total Disability, even though he or she may not, in fact, be receiving Medicare or Medicaid, the Participant's Spouse and/or eligible dependent children may make self-payment contributions at 100% of the self-payment rate required to cover his, her and/or their monthly benefit plan premium charge(s), to continue eligibility for coverage under the Plan until the earlier of:

(i) The date the Participant's dependent child(ren) no longer meet the definition of eligible dependent; or

(ii) The date the Participant's Spouse or dependent child(ren) become eligible for Medicare or Medicaid, even though the Participant's Spouse or dependent child(ren) may not, in fact, be receiving Medicare or Medicaid.

(e) **Return to Work from Total Disability - Reinstatement**
When a Participant returns to work from Total Disability, his or her eligibility for coverage under the Plan continues for three consecutive calendar months after the month in which his or her Total Disability ends. To remain eligible after this three-month extension of disability coverage, the Participant must meet the Plan's "*Continuation of Eligibility*" requirements described above in this section II.

(f) **Eligibility for Participants Age 65 and Older**

(i) **Eligibility until Retirement**
If you are age 65 or older, you may continue to use the funds in your HRA (or Dollar Bank, if applicable) or make self-payments to continue your coverage until the last day of the third month following the month in which you retire.

(ii) **Limited Eligibility after Retirement**
If you retire at or after age 65, your coverage under the Plan will end on the last day of the third month following the month in which you retire, regardless of your HRA balance (or Dollar Bank balance, if applicable).

Even if your coverage ends in this manner, your covered Spouse or covered dependent child may be eligible to continue coverage under the Plan's Retiree Program, provided they waive COBRA continuation rights and continue to meet the Plan's definition of an eligible Spouse or eligible dependent child. Your eligible Spouse or dependent child may pay the monthly benefit plan premium charge by using your HRA (and Dollar Bank, if applicable) or by making self-payments. Refer to the *Continued Coverage for Retiree's Spouse* and *Continued Coverage for Retiree's Dependent Children* sections under *Retiree Program* below for details.

The monthly benefit plan premium charge required is determined by the Trustees as needed. Self-payments must be received by the Administrative Manager by the 28th of the month before the coverage month for which payment is due. All notices are sent to the last known address on file with the Administrative Manager, so it is important that any address changes be reported to the Administrative Manager immediately.

(iii) **Retirement Defined**
If you are age 65 or older, you will be considered to have retired as of the last day of the month prior to a three-consecutive-month period during which no Contributing Employer makes contributions to the Plan on your behalf. For example, if no Contributing Employer contributes to the Plan on your behalf in January, February, or March, you will be deemed to have retired effective as of December 31, and your coverage would terminate after March 31. However, you may show that you are not retired, despite having no contributions made on your behalf for three consecutive months, by submitting evidence satisfactory to the Trustees that you are actively seeking work or show intent to return to work with a Contributing Employer. Such evidence must be submitted to the Administrative Manager prior to your coverage being terminated. In the example above, evidence must be received by March 31.

(iv) **Post-Retirement Work**
If you engage in covered employment for a Contributing Employer after you are age 65 or older and are considered retired, any contributions made to the Plan on your behalf will be added to your HRA.

(g) **Eligibility for Participants Working in the Electrical Industry, Outside of the I.B.E.W. Local 405 Jurisdiction, without Reciprocity**
If a Participant leaves the jurisdiction of I.B.E.W. Local 405 to work under the jurisdiction of another I.B.E.W. local union that DOES NOT have a reciprocal agreement with the Plan, the Participant's eligibility (and that of any dependents) will terminate on the earlier of:

(i) The first day of the month in which the Participant does not meet the Plan's *Continuation of Eligibility* requirements described above in this section II.A.(4); or

(ii) The date in which the Participant becomes eligible for benefits under any other group health plan; or

(iii) The last day of the month in which the Participant ceases working in covered employment under the I.B.E.W. Local 405 jurisdiction.

(h) **Return to Jurisdiction (Reinstatement of Eligibility)**
If a Participant returns to covered employment in the I.B.E.W. Local 405 jurisdiction, eligibility to participate in the Plan will be reinstated on the date he or she first returns to covered employment for a Contributing Employer, provided:

(i) The Participant filed a written notification of leave with the Administrative Manager prior to the date he or she left the I.B.E.W. Local 405 jurisdiction;

(ii) The Participant returns to covered employment in the I.B.E.W. Local 405 jurisdiction within 12 calendar months of his or her termination of past eligibility; and

(iii) The Participant performed at least 304 hours of covered employment for which a Contributing Employer made contributions to the Plan on his or her behalf during the three calendar months immediately prior to the month in which he or she left the I.B.E.W. Local 405 jurisdiction and his or her termination of eligibility occurred.

If a Participant does not meet requirements set forth above, eligibility for coverage under the Plan will be reinstated using the Plan's *Initial Eligibility* requirements described in above in this section II.

(i) **Eligibility for Participants Working in the Electrical Industry, Outside the I.B.E.W. Local 405 Jurisdiction, with Reciprocity**
The Trustees have entered into reciprocity agreements with the trustees of similar I.B.E.W. health and welfare funds operating in jurisdictions of other I.B.E.W. local unions. Under these agreements, contributions for hours worked at covered employment in the jurisdiction of another I.B.E.W. local union may be transferred to the Plan for use in continuing a Participant's eligibility.

The amount of contributions that may be transferred and the way such transfers are credited to Participant records are governed by the reciprocity agreements and by the administrative

procedures adopted by the Trustees. A Participant should inquire about the availability of reciprocal transfers with the Administrative Manager BEFORE he or she leaves the I.B.E.W. Local 405 jurisdiction.

(j) **Continuation of Eligibility for Dependents in the Event of a Participant's Death**
If a Participant dies, eligibility for such Participant's surviving dependents will continue automatically, without self-payment contributions, so long as the surviving dependents continue to meet the definition of dependent, until the later of:

(i) The eligibility termination date based on when the deceased Participant's HRA (and Dollar Bank, if applicable) equals zero; or

(ii) The last day of the sixth calendar month following the month in which the Participant died.

Eligibility for surviving dependents may then be continued under COBRA provisions. See the *COBRA Continuation Coverage* section of this SPD for more information.

(k) **Continuation of Eligibility When Entering Qualified Military Service**
Participants entering or returning from qualified military service may elect, as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), to continue coverage under the Plan. See the *Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")* section of this SPD.

A Participant's accumulated HRA (and Dollar Bank, if any), will be kept on record with the Administrative Manager, provided the Participant notifies the Administrative Manager in writing that he or she is entering active duty military service in any of the uniformed services of the United States. Such accumulated amounts will be made available to the Participant upon discharge from military service and return to covered employment for a Contributing Employer. If covered employment is available and the Participant is medically fit to perform covered employment, he or she must return to covered employment for a Contributing Employer within 90 days after discharge from military service in order to retain his or her rights to continued coverage under the Plan. The Participant's eligibility and that of his or her eligible dependents, if any, will then be reinstated on the day the Participant returns to covered employment for a Contributing Employer, unless the Participant elects to delay reinstatement of eligibility for himself or herself and any eligible dependents for up to four months following the date the Participant returned to covered emplyment for a Contributing Employer. The Participant must notify the Administrative Manager if he or she wishes to delay reinstatement of eligibility. Premium charges against the Participant's HRA will resume as of the first day of the month following the month in which the Participant's eligibility is reinstated. If the Participant fails to return to work for a Contributing Employer within 90 days from the date he or she returns from active duty military service, the Participant's HRA (and Dollar Bank, if applicable) will be reduced to zero and the Participant must again satisfy the requirements set forth in the *Initial Eligibility* section of this SPD to reinstate his or her eligibility.

5. **<u>Reinstatement of Eligibility</u>**
Unless stated otherwise in this SPD, the requirements for reinstatement of eligibility for coverage under the Plan are the same as the requirements for obtaining initial eligibility, set forth in the *Initial Eligibility* section of this SPD. Upon reinstatement of eligibility, the Participant and his or her eligible dependents, if any, become eligible for all benefits provided under the Plan.

6. **Retiree Program**

Bargaining unit Participants who meet the *General Eligibility Requirements* below may continue coverage under the Plan as described below. Retiree Program coverage does not include short term disability benefits, life insurance or accidental death and dismemberment (AD&D) benefits.

(a) **General Eligibility Requirements**

Each retired Participant may continue coverage for himself or herself and his or her eligible dependents through the Plan under the Retiree Program, provided he or she meets all of the following requirements:

(i) The Participant is at least 62 years old; and

(ii) The Participant has been eligible to participate in the Plan for at least nine consecutive months during each of the five calendar years immediately prior to his or her request for coverage under this Retiree Program.

If a retired Participant is eligible to participate in the Plan's Retiree Program, he or she must exercise the option when first eligible to do so. ***If a retired Participant does not exercise his or her option to participate in the Retiree Program immediately upon retirement, he or she will not be allowed to participate at a later date.***

The retired Participant may use the remaining balance in his or her HRA (or Dollar Bank, if applicable) or make self-payment contributions to maintain eligibility in the Plan's Retiree Program; the monthly amount required is determined by the Trustees as needed. Self-payments must be received by the Administrative Manager by the 28th of the month before the coverage month for which payment is due. **All notices are sent to the last known address on file with the Administrative Manager, so it is important that any address changes be reported to the Administrative Manager immediately.**

(b) **Termination of Participant Coverage**

A retired Participant may maintain coverage under the Plan's Retiree Program, regardless of whether the retiree has a remaining balance in his or her HRA (or Dollar Bank, if applicable) or whether the retiree chooses to purchase Medicare Part B coverage, until his or her coverage terminates upon the earliest of the following:

(i) The last day of the month preceding the month in which the retiree first becomes entitled to Medicare benefits due to reaching age 65;

(ii) The last day of the month preceding the month in which the retiree first becomes entitled to Medicare benefits due to disability; or

(iii) The last day of the 30th month during which the retiree is entitled to Medicare based on end-stage renal disease ("ESRD").

If the retired Participant has no dependents, the retiree's Dollar Bank balance will be reduced to zero upon termination of the retiree's coverage under the Plan's Retiree Program. The retired Participant may continue to receive reimbursements for medical, dental and vision expenses from his or her HRA until the balance is reduced to zero.

(c) **Continued Coverage for Retiree's Spouse**

The Spouse of a retired Participant may continue coverage for himself or herself under the Plan's Retiree Program after the retired Participant's coverage is terminated, provided the Spouse waives his or her right to COBRA continuation coverage and continues to meet the Plan's definition of an eligible Spouse. The Spouse of a retired Participant may maintain eligibility for coverage under the Retiree Program using the Participant's remaining HRA balance (and Dollar Bank, if applicable) or self-payment contributions until the earliest of:

(i) The last day of the month preceding the month in which the retiree's Spouse first becomes entitled to Medicare due to reaching age 65;

(ii) The last day of the month preceding the month in which the retiree's Spouse first becomes entitled to Medicare benefits due to disability;

(iii) The last day of the 30th month during which the retiree's Spouse is entitled to Medicare based on ESRD; or

(iv) The last day of the month in which the retiree's Spouse ceases to meet the Plan's definition of an eligible Spouse.

(d) **Continued Coverage for Retiree's Dependent Children**
A dependent child of a retired Participant may continue coverage for himself or herself under the Plan's Retiree Program after the retired Participant's coverage is terminated, provided the dependent child waives his or her right to COBRA continuation coverage and continues to meet the Plan's definition of an eligible dependent child. The dependent child of a retired Participant may maintain eligibility for coverage under the Retiree Program using the Participant's remaining HRA balance (and Dollar Bank, if applicable) or self-payment contributions until the earliest of:

(i) The last day of the month preceding the month in which the retiree's Spouse first becomes entitled to Medicare due to reaching age 65;

(ii) The last day of the month preceding the month in which the retiree's Spouse first becomes entitled to Medicare benefits based on disability;

(iii) The last day of the 30th month during which the retiree's Spouse is entitled to Medicare based on ESRD; or

(iv) The last day of the month in which the child no longer meets the requirements to be considered an eligible dependent child of the retiree.

7. **Employment Changes May Affect Eligibility**
Changes in employment may have an effect on contributions paid by a Contributing Employer on the Participant's behalf. For example, Contributing Employers may cease making contributions on behalf of a Participant in the event such Participant:

(a) Changes job classifications from covered employment to non-covered employment, even if such employment is with the same Contributing Employer, or

(b) Changes employment from a Contributing Employer to a non-Contributing Employer.

The Participant and his or her eligible dependents may obtain, upon written request to the I.B.E.W. Local 405 Union Office or Administrative Manager, information regarding a particular employer and whether such employer is a Contributing Employer of the Plan.

As noted above, if a Bargaining Unit Employee changes job classifications from covered employment to non-covered employment, but remains covered by the Plan as a Non-Bargaining Unit Employee, the Participant's HRA will remain available for payment of claims, but will receive no further contributions, and his or her Dollar Bank will be reduced to zero. If the Participant returns to covered employment within 12 months of the beginning of non-covered employment, the Participant may apply to the Trustees for reinstatement of his or her Dollar Bank. Contact the Administrative Manager to apply.

8. **Change of Requirements for Eligibility**

The Trustees, in their sole discretion, have the right, power and authority to change or amend these requirements for eligibility under the Plan at any time, provided that such changes are prospective in effect and not inconsistent with law.

The eligibility requirements set forth herein must be satisfied in order for a Participant and his or her dependent(s) to become and remain eligible to receive benefits under the Plan. In the event applicable requirements are not satisfied, eligibility will be lost and benefits will not be payable. Benefits are only provided if the Trustees (or their delegate) decide, in their sole discretion, that an individual is entitled to such benefits under the Plan's terms. Only the Trustees are authorized to interpret the Plan's eligibility provisions; such interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. Eligibility matters that are not clear, or that need interpretation, will be referred to the Trustees.

B. Eligibility - Non-Bargaining Unit Employees

The Trustees have agreed to allow certain Contributing Employers to contribute to the Plan on behalf of certain individuals employed by the Contributing Employer on a full-time basis who do not perform work covered under the I.B.E.W. Local 405 jurisdiction collective bargaining agreements; such individuals are referred to as Non-Bargaining Unit Employees or "NBU Employees."

1. **Employer Obligations**

   Employers that want to provide coverage under the Plan for their NBU Employees must meet the following requirements for their NBU Employees to be eligible to participate in the Plan:

   (a) Agree to follow the terms of the Plan's Trust Agreement;

   (b) Agree to contribute to the Plan on behalf of their NBU Employees; and

   (c) Execute a separate written participation agreement, approved by the Trustees.

   If an Employer is at any time delinquent in making contributions on behalf of its Employees (including Bargaining Unit Employees and NBU Employees) covered under the Plan, the Employer's NBU Employees may lose their eligibility for coverage under the Plan, effective as of the first day such contributions are delinquent, or as otherwise provided in the participation agreement. Such NBU Employees may have their eligibility restored upon the Employer's payment of delinquent contributions, plus interest and penalties, after review and approval by the Trustees.

2. **Eligibility Requirements for NBU Employees**

   Eligibility requirements are generally established by the Employer, set forth in a written participation agreement, and approved by the Trustees. Unless otherwise specified by the participation agreement, coverage for full-time NBU Employees becomes effective as of the first day of the month following 30 days of full-time employment with the Employer. "Full-time" is defined by the Employer.

3. **Benefit Coverage for NBU Employees**

   (a) **Benefits Covered**

   All NBU Employees are eligible for medical, prescription drug, dental, vision, life insurance and accidental death and dismemberment (AD&D) benefits under the Plan.

   (b) **Short Term Disability**

   NBU Employees are eligible for short term disability benefits under the Plan only if the Employer has agreed to sponsor such benefits for NBU Employees under the participation agreement.

   (c) **Benefits Not Covered**

   NBU Employees are generally not eligible for HRA benefits under the Plan. However, if an NBU Employee was previously covered under the Plan as a Bargaining Unit Employee and has a balance remaining in his or her HRA, the NBU Employee may utilize his or her HRA balance for reimbursement of medical, dental and vision expenses as permitted under the Plan. Such NBU Employee will receive no further contributions to his or her HRA (unless he or she returns to covered employment). When an NBU Employee's Plan coverage ends, the Non-Bargaining Unit Employee's HRA will no longer be available for reimbursement of expenses, except if continuation coverage is available and elected.

   NBU Employees are not eligible to participate in the Plan's Retiree Program.

C. Eligibility - Dependents

1. **Dependent Eligibility**
The following persons may be eligible for dependent coverage under the Plan for medical, prescription drug, dental and vision benefit coverage:

(a) **Spouse** – The term "Spouse" refers to an individual lawfully married to a covered Participant under any state law (or the law of any U.S. territory or possession or any foreign jurisdiction with legal authority to sanction marriages), including common law marriage, regardless of where the couple lives, provided such individual is not legally separated or divorced from the Participant. The Administrative Manager may require documentation proving a legal marital relationship exists. Domestic partnerships are not considered eligible for spousal coverage.

(b) **Children**

(i) The term "child" or "children" as referenced in this subsection (b) includes:

(A) A Participant's natural child;

(B) A Participant's adopted child (from the date of placement), which refers to a child whom the Participant has adopted or intends to adopt, whether or not the adoption has become final, and who has not attained age 18 on the date of such placement for adoption. The term "placement" means the assumption and retention by such Participant of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced;

(C) A Participant's stepchild;

(D) A Participant's grandchild until the dependent grandchild's parent is age 19;

(E) Any other child for whom the Participant has legal guardianship or a child for whom the Participant had noted legal guardianship on the child's 18th birthday (proof is required).

(ii) **Children to Age 26** – A Participant's child, up to age 26, is eligible for coverage under the Plan regardless of marital or employment status, or existence of other coverage. However, if the child has coverage through his or her own employer or through his or her own spouse, then coverage by the Plan will pay all benefits as secondary to that coverage as outlined in the *Coordination of Benefits* section later in this SPD. When the child reaches the limiting age of 26, coverage will end as of the last day of the month in which the child reaches age 26.

(iii) **Developmentally Disabled or Physically Handicapped Children** – A Participant's unmarried dependent child who is incapable of self-sustaining employment by reason of developmental disability or physical handicap, who is primarily dependent upon the Participant for support and maintenance and who is covered under the Plan when the child reaches age 26. Proof of physical or mental handicap must be submitted to the Administrative Manager within 60 days of the covered dependent reaching age 26. Thereafter, proof may be required annually. In the event proof is not submitted within 60 days, the Administrative Manager may request proof, which must be submitted within 30 days of such request. Extensions to the period for submission of proof are available upon request in cases where there is a legitimate reason or hardship involved in meeting the

request. The Trustees reserve the right to have such dependent examined by a physician of the Trustees' choice at the Plan's expense, to determine the existence of such incapacity.

2. **Dependent Effective Date**
Provided an enrollment form is timely received by the Administrative Manager, dependent coverage becomes effective as follows:

(a) **Initial Enrollment** – If an Employee has eligible dependents at the time he or she initially enrolls for coverage under the Plan, such dependents will become covered on the same date as the Employee.

(b) **New Dependents** –

(i) **Birth or Adoption** – If a Participant acquires a new dependent by birth or adoption after the Participant's initial effective date of coverage under the Plan, then the new dependent is covered as of the date of the birth or placement for adoption, provided the dependent is enrolled for coverage under the Plan within one year of the date of birth or placement for adoption. If enrollment is requested after the one-year time period, then coverage is effective on the first of the month after the completed enrollment form is received by the Administrative Manager.

(ii) **Court Ordered** – If a Participant acquires a new dependent due to a court order of guardianship or marriage, coverage under the Plan will be effective as of the date of the court order or marriage, provided the dependent is enrolled within 31 days of the date of the court order or marriage. If enrollment is requested after the 31-day time period, then coverage is effective on the first day of the month after the completed enrollment form is received by the Administrative Manager.

(iii) **Medicaid or Children's Health Insurance Program (CHIP) Coverage**

(A) If a dependent's Medicaid or CHIP coverage is terminated due to loss of eligibility, coverage under the Plan will be effective on the first day of the month after a completed enrollment form is received by the Administrative Manager, provided it is received within 60 days of the termination of the other coverage.

(B) If a dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, coverage under the Plan will be effective on the first day of the month after a completed enrollment form is received by the Administrative Manager, provided it is received within 60 days of the eligibility for premium assistance.

(iv) **Qualified Medical Child Support Orders (QMCSOs)** – A QMCSO is a judgment, decree or order issued by a court or appropriate state agency that requires an Employee to provide medical benefits coverage for a child and meets the requirements of ERISA section 609(a). Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement. If a Participant is required to enroll a dependent child as a result of a QMCSO, the effective date of coverage under the Plan will be the first day of the month following the date the order was received by the Administrative Manager, provided the Administrative Manager determines the order meets the requirements for a QMCSO.

The Plan will provide benefits in accordance with the applicable requirements of any QMCSO. Participants may obtain, without charge, a copy of the procedures governing

QMCSOs from the Administrative Manager. A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

(v) **Loss of Other Coverage** – If a Participant's dependent was not enrolled when coverage under the Plan was last offered due to the dependent's coverage under another group health plan or health insurance coverage, and the dependent exhausts other COBRA continuation coverage, loses eligibility for coverage through his or her employer (or, for a child, the non-Participant parent's employer) or if such an employer ceases making contributions for coverage, the effective date of coverage under the Plan will be the first day of the month after the completed enrollment form is received by the Administrative Manager.

D. Rules for Dual Eligibility

Special rules apply to Employees eligible for coverage under the Plan who have spouses or eligible dependent children who are also eligible for coverage under the Plan as Employees.

1. **Both Spouses Are Eligible Employees**

   (a) **Both Spouses Are Bargaining Unit Employees**
   If both spouses are eligible Bargaining Unit Employees, then both spouses must be enrolled in the Plan as Participants. As Participants, each spouse can elect to enroll in either of the Plan's benefit coverage options (Orange Plan or Yellow Plan) and can enroll his or her spouse as an eligible dependent Spouse into the Plan. Also, as Participants, each spouse can elect to enroll any of the couple's eligible dependent children into the Plan. If both Participant spouses elect to enroll one another as dependent Spouses, or if both Participant spouses elect to enroll any of the couple's eligible dependent children, the Plan will apply Coordination of Benefits rules, which may result in coverage of expenses up to 100% of the maximum allowable expense for services rendered.

   (b) **Both Spouses Are NBU Employees**
   If both spouses are eligible NBU Employees, then each spouse can enroll in the Plan separately as Participants, but only one spouse can enroll eligible dependent children. Alternatively, one spouse (but not both) can enroll in the Plan as a Participant, and can enroll his or her spouse as a dependent Spouse and any of the couple's eligible dependent children into the Plan. If one of the spouses loses eligibility for coverage under the Plan as a Participant, the spouse that remains an eligible NBU Employee will have the opportunity to enroll him/herself, his or her spouse (provided the spouse remains eligible for coverage as a dependent under the Plan) and any eligible dependent children into the Plan within 31 days of the loss of eligibility.

   (c) **One Bargaining Unit Employee Spouse, one NBU Employee Spouse**
   If both spouses are eligible Employees, but one spouse is a Bargaining Unit Employee and the other is an NBU Employee, the Bargaining Unit Employee must be enrolled in the Plan as a Participant. The Bargaining Unit Employee may enroll the NBU Employee as a dependent Spouse and any eligible dependent children as a family unit in either of the Plan's benefit coverage options (Orange Plan or Yellow Plan). Alternatively, each spouse may enroll in the Plan separately as Participants, and one spouse (but not both) can elect to enroll any of the couple's eligible dependent children into the Plan. If one of the spouses loses eligibility for coverage under the Plan as a Participant, the spouse that remains an eligible Employee will have the opportunity enroll himself/herself, his or her spouse (provided the spouse remains eligible for coverage as a dependent under the Plan) and any eligible dependent children into the Plan within 31 days of the loss of eligibility.

2. **Parent and Child Are Eligible Employees**

   (a) **Bargaining Unit Employee Child**
   If a Participant parent has an eligible dependent child who is also an eligible Bargaining Unit Employee, the child must be enrolled in the Plan as a Participant. The parent may also elect to enroll the child into the Plan as a dependent so long as the child remains eligible for dependent coverage. In such event, the Plan will pay primary benefits for the child as a Participant, and secondary benefits for the child as a dependent.

   (b) **NBU Employee Child**
   If a Participant parent has an eligible dependent child who is also an eligible NBU Employee, the child may be enrolled as either a Participant under the Plan or as a dependent child of the parent, but not both.

E. Coverage Change and Termination Events

1. **Enrollment Events**

(a) **General** – The following events may allow you, as well as an affected Spouse or eligible dependent child, to enroll for coverage under the Plan or switch from one of the Plan's benefit coverage options (Orange Plan or Yellow Plan) to another:

(i) Birth, adoption, or placement for adoption by an approved agency. If the newborn or newly adopted child is enrolled later than 60 days following the birth or adoption, you will not be allowed to change Plan benefit coverage options at the same time, unless the enrollment coincides with the annual enrollment period.

(ii) Marriage.

(iii) Exhaustion of COBRA continuation coverage.

(iv) You or your Spouse or dependent child lose eligibility for creditable coverage, or the employer or group sponsor for such individual ceases contribution to creditable coverage.

The term "creditable coverage" as used above generally refers to coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, medical care for members of the uniformed services, the medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool, CHIP, public health plan defined in federal regulations (e.g., FEHBP), or a health benefits plan under the Peace Corps Act.

(v) Your Spouse or dependent child lose coverage through his or her employer.

(vi) You or your Spouse or dependent child lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the hawk-I plan in Iowa).

(vii) You or your Spouse or dependent child become eligible for premium assistance under Medicaid or CHIP.

(b) **New Dependents**–- The following events allow you to add only the new dependent resulting from the event:

(i) Addition of a natural child by court order.

(ii) Appointment as a child's legal guardian.

(iii) Placement of a foster child in your home by an approved agency.

2. **Disenrollment Events**

(a) **General**–- The following events require you to notify the Administrative Manager to remove the affected Covered Person from your coverage:

(i) Death.

(ii) Divorce, annulment or legal separation. You must notify the Administrative Manager immediately if you have a divorce, annullment, or legal separation from your Spouse.

(iii) Medicare eligibility–- If you become eligible for Medicare, you must notify the Administrative Manager immediately. If you are eligible for coverage under the Plan other than as an active Employee or an active Employee's Spouse, your Medicare eligibility may terminate this coverage.

(iv) Child loses dependent status or eligibility as a dependent.

(b) **Limited Extension of Coverage for Affected Dependent Child** - In case of the following coverage removal events, the affected dependent child's coverage may be continued until the end of the month on or after the date of the event:

(i) A child who is not developmentally disabled or physically handicapped reaches age 26.

(ii) Marriage of a developmentally disabled or physically handicapped child age 26 or older.

3. **Requirement to Notify Administrative Manager**

You must notify the Administrative Manager within 31 days of most events that change your coverage status under the Plan, but within 60 days of events related to Medicaid or CHIP eligibility. If you enroll newly eligible dependents later than the applicable 31- or 60-day enrollment window following the event, you will not be allowed to change plan options at the same time, unless the later enrollment coincides with the annual enrollment period.

You must notify the Administrative Manager immediately if there is any change in your family status because of death, divorce, annullment, legal separation, or a child loses dependent status or eligibility as a dependent. If you do not provide timely notification of an event that terminates dependent eligibility of an affected individual, you (and your Spouse, if applicable) may be held responsible for any benefits paid by the Plan after the individual lost eligibility for dependent coverage, and your and your family's coverage under the Plan may be delayed, suspended or terminated.

The Administrative Manager may request appropriate documentation for any change in enrollment status (*e.g.*, birth certificate for newborn, divorce decree, etc.). Failure to provide appropriate documentation within a reasonable period of time from the request may result in delay, suspension or termination of coverage.

4. **Coverage Termination**

In general, coverage terminates upon the earliest to occur of the following events:

(a) The end of the month in which you no longer meet the Plan's eligibility requirements;

(b) The date the Plan discovers you have perpetrated fraud or an intentional misrepresentation of material facts with respect to your enrollment in the Plan or any claim for benefits from the Plan; or

(c) The Trustees discontinue or replace the Plan.

F. Continuation of Coverage Events

Certain laws require that coverage under the Plan continue when it might otherwise end.

1. **Family and Medical Leave Act ("FMLA")**
   The Plan will comply with the requirement to allow Participants to continue group health coverage (*i.e.*, medical, prescription drug, dental, vision, HRA and EAP benefits) under the Plan while on leave, to the extent required by any applicable federal and/or state FMLA laws.

2. **Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**
   The Plan will fully comply with USERRA. If any part of the Plan conflicts with USERRA, the conflicting provision will not apply. All other benefits and exclusions under the Plan will remain effective to the extent there is no conflict with USERRA.

   USERRA provides for, among other employment rights and benefits, continuation of health care coverage (*i.e.*, medical, prescription drug, dental, vision, HRA and EAP benefits under the Plan) to a covered Participant and the Participant's covered dependents during a period of the Participant's active service or training with any of the uniformed services ("USERRA leave"). The Plan provides that a Participant may elect to continue coverages in effect at the time the Participant begins USERRA leave, by following the same procedures and time frames that apply to the election of COBRA continuation coverage. The maximum period of coverage for a Participant and the Participant's dependents under such an election will be the lesser of:

   (a) The 24-month period beginning on the date on which the covered Participant's USERRA leave begins; or

   (b) The period beginning on the date on which the covered Participant's USERRA leave begins and ending on the day after the date on which the covered Participant fails to apply for or return to a position of employment as follows:

      (i) For service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of 8 hours after a period allowing for the safe transportation from the place of service to the Participant's residence or as soon as reasonably possible after such 8-hour period;

      (ii) For service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;

      (iii) For service of more than 180 days, no later than 90 days after the completion of the period of service; or

      (iv) For a Participant who is hospitalized or convalescing from an Illness or Injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the Participant to recover from the Illness or Injury. The period of recovery may not exceed two years.

   A Participant who elects to continue coverage under the Plan during USERRA leave may be required to pay no more than 102% of the full premium under the Plan associated with the coverage for the Plan's other Participants. This is true except in the case of a Participant who is on USERRA leave for less than 31 days. When this is the case, the Participant may not be required to pay more than the Participant's share, if any, for the coverage. Continuation of coverage cannot be discontinued merely

because activated military personnel receive health coverage as active duty members of the uniformed services and their family members are eligible to receive coverage under the TRICARE program.

If a Participant's coverage under the Plan was terminated for USERRA leave, any waiting period may not be imposed in connection with the reinstatement of the coverage upon reemployment under USERRA. This applies to a Participant who is reemployed and any eligible dependent of the Participant whose coverage is reinstated.

Uniformed services includes full-time and reserve components of the United States Army, Navy, Air Force, Marines and Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a Participant called to a period of active service in the uniformed services, you should check with the Administrative Manager for a more complete explanation of your rights and obligations under USERRA.

3. **COBRA Continuation Coverage**

Under federal law, specifically the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), certain Participants and their families covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This applies to the medical, prescription drug, dental, vision, HRA and EAP benefits under the Plan.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Participants who become Qualified Beneficiaries under COBRA.

(a) **COBRA Continuation Coverage Defined**

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Participants who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

(b) **Qualified Beneficiary Defined**

In general, a Qualified Beneficiary can be:

(i) Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a Participant, the Spouse of a Participant, or a dependent child of a Participant. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a Participant during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an

alternate recipient under a QMCSO. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

An individual is not a Qualified Beneficiary if the individual's status as a Participant is attributable to a period in which the individual was a nonresident alien who received no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a Participant during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

(c) **What is a Qualifying Event?**

A Qualifying Event is any of the following if the Plan provided that the Participant would lose coverage (*i.e.*, cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) within the maximum COBRA continuation period:

(i) The death of a Participant.

(ii) The termination (other than by reason of gross misconduct) of a Participant's employment or reduction of working hours.

(iii) The divorce or legal separation of a Participant from the Participant's Spouse.

(iv) A Participant's eligibility for enrollment in any part of the Medicare program.

(v) A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the Participant, or the Participant's Spouse or a dependent child, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA are also met. For example, any increase in contribution that must be paid by a Participant, or the Participant's Spouse or a dependent child, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event will occur, however, if the Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the Participant and eligible family members will be entitled to COBRA

continuation coverage even if they failed to pay any applicable premiums for coverage under the Plan during the FMLA leave.

(d) **Procedure for Obtaining COBRA Continuation Coverage**
The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period for COBRA continuation coverage, described below.

(e) **Election Period Defined**
The election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage.

Note: If a Participant who has been terminated or experienced a reduction of working hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Participant and his or her covered dependents have not elected COBRA continuation coverage within the normal election period, a second opportunity to elect COBRA continuation coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the 6 months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the COBRA Administrator for further information.

(f) **Responsibility for Informing the COBRA Administrator of the Occurrence of a Qualifying Event**
The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator has been timely notified that a Qualifying Event has occurred. The COBRA Administrator will determine whether a Qualifying Event due to the end of employment, reduction of hours of employment or Medicare entitlement has occurred. The Contributing Employer will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(i) Death of the Participant, or

(ii) Commencement of a proceeding in bankruptcy with respect to the Contributing Employer.

IMPORTANT:
For the other Qualifying Events (divorce or legal separation of the Participant and Spouse or a dependent child's loss of eligibility for coverage as a dependent child), the Participant or Qualified Beneficiary must notify the COBRA Administrator in writing within 60 days after the Qualifying Event occurs, using the notice procedures specified below. If these notice procedures are not followed or if the notice is not provided in writing to the COBRA Administrator or its designee during the 60-day notice period, any Spouse or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

F. Continuation of Coverage Events

COBRA QUALIFYING EVENT NOTICE PROCEDURES:

Any notice provided by a Participant or Qualified Beneficiary must be ***in writing***. Oral notice, including notice by telephone or in person, is not acceptable. The written notice must be provided to the COBRA Administrator using the following contact information:

Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund
c/o Auxiant
424 1st Avenue, NE
Cedar Rapids, IA 52401
Fax: 319-866-9889
Email: cobra@auxiant.com

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice must state:

(i) the **name of the Plan**;

(ii) the **name and address of the Participant** covered under the Plan;

(iii) the **name(s) and address(es) of the Qualified Beneficiary(ies)**; and

(iv) the type of **Qualifying Event** and the **date** it occurred.

If the Qualifying Event is a **divorce or legal separation**, the notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, such as in order to qualify for a disability extension. Contact the COBRA Administrator for more information.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect or waive COBRA continuation coverage. Participants and Spouses may elect COBRA continuation coverage for all other Qualified Beneficiaries in the family, and parents may elect COBRA continuation coverage on behalf of their children who are Qualified Beneficiaries. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage under the Plan would otherwise have been lost. If the Participant or his or her Spouse or dependent children do not elect COBRA continuation coverage within the 60-day election period described above, the right to elect COBRA continuation coverage will be lost.

(g) **Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. If a waiver is later revoked, COBRA continuation coverage will be provided retroactively to the date coverage was originally lost. Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

(h) **Termination of COBRA Continuation Coverage**
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Trustees discontinue all coverage under the Plan.

(iv) The date after the date of the election, that the Qualified Beneficiary first becomes covered under any other group plan that does not contain any exclusion or limitation with respect to any Pre-Existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election that the Qualified Beneficiary first becomes enrolled in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(A) The earlier of:

(1) 29 months after the date of the Qualifying Event, or

(2) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled; or

(B) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, such as for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

(i) **Maximum Coverage Periods for COBRA Continuation Coverage**
The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event

if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a Participant's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Participant ends on the later of:

(A) 36 months after the date the Participant becomes enrolled in the Medicare program; or

(B) 18 months (or 29 months, if there is a disability extension) after the date of the Participant's termination of employment or reduction of hours of employment.

(iii) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Participant during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(iv) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

(j) **Maximum Coverage Period Expanded**
If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the occurrence of the second Qualifying Event.

(k) **Disability Extension**
A disability extension will be granted if an individual (whether or not the Participant) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the COBRA Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

(l) **Payment Requirements for COBRA Continuation Coverage**
For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

The Plan is also permitted to allow for payment at other intervals.

F. Continuation of Coverage Events

(m) **Timely Payment for COBRA Continuation Coverage**

Timely payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered timely payment if either, under the terms of the Plan, Participants or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan's COBRA Administrator.

If timely payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a timely payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

(n) **Address Changes**

In order to protect a Participant's family's rights, a Participant must notify the COBRA Administrator of any changes in the addresses of family members. The Participant should retain a copy of any notices he or she sends to the COBRA Administrator for his or her records.

Section III

Medical and Prescription Drug Benefits

IMPORTANT NOTES ABOUT THIS SECTION

Information contained in this section III, *Medical and Prescription Drug Benefits*, was prepared by Wellmark Blue Cross and Blue Shield of Iowa ("Wellmark"), the Plan's Medical Benefits Claims Administrator and Prescription Benefit Manager. The information describes how Wellmark processes medical and prescription drug benefit claims under the Plan.

The definitions of terms used in this section III might not apply to other sections of this SPD. Please keep in mind the following while reviewing this section III:

- The terms "we" and "our" refer to Wellmark.
- The phrases "this group health plan" and "your employer or group sponsor" refer to the Plan (the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund). Refer to the *Your Plan Identification at a Glance* section in this SPD for applicable contact information as needed.
- The term "benefit year" generally refers to a Plan Year (January 1 through December 31; a calendar year); however, if your coverage begins after January 1, a "benefit year" begins on the day your coverage goes into effect and ends on December 31.
- The term "member" refers to a Covered Person (any Employee, or dependent of an Employee, who meets the eligibility requirements for coverage as specified in this SPD, and who is properly enrolled in the Plan).

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

AllianceSelect℠
Blue Rx Value Plus℠

Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund

Orange and Yellow Plans

NOTICE

This group health plan is sponsored by the Board of Trustees of the Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund (the "Plan"). The Plan is funded by Contributing Employers pursuant to collective bargaining or other written participation agreements. The Plan has a financial arrangement with Wellmark under which the Plan is solely responsible for claim payment amounts for covered medical services provided to you. Wellmark provides administrative services and provider network access only and does not assume any financial risk or obligation for claim payment amounts.

QUESTIONS

If you have questions about your group health plan, or are unsure whether a particular medical service or supply is covered, call the Wellmark Customer Service number on your ID card or the Administrative Manager.

Please note, certain page numbers have been skipped intentionally and are not missing from the Plan's SPD.

A. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire summary plan description, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

PPO Providers. These providers participate with the Wellmark Blue PPO℠ network or with a Blue Cross and/or Blue Shield PPO network in another state or service area. You typically pay the least for services received from these providers. Throughout this summary plan description we refer to these providers as PPO Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO network. You typically pay more for services from these providers than for services from PPO Providers. Throughout this summary plan description we refer to these providers as Participating Providers.

Out-of-Network Providers. Out-of-Network Providers do not participate with Wellmark or any other Blue Cross and/or Blue Shield Plan. You typically pay the most for services from these providers.

Payment Summary

This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

Medical

You Pay
Deductible **Orange Plan** **$1,000** per person for covered services received from PPO Providers. **$2,000** (maximum) per family* for covered services received from PPO Providers. **$2,000** per person for covered services received from Participating and Out-of-Network providers. **$4,000** (maximum) per family* for covered services received from Participating and Out-of-Network providers. **Yellow Plan** **$2,000** per person for covered services received from PPO Providers. **$4,000** (maximum) per family* for covered services received from PPO Providers. **$4,000** per person for covered services received from Participating and Out-of-Network providers. **$8,000** (maximum) per family* for covered services received from Participating and Out-of-Network providers.
Emergency Room Copayment **$200**

You Pay
Office Visit Copayment **Orange Plan** **$20** for covered services received from PPO practitioners.
Yellow Plan **$30** for covered services received from PPO practitioners.
Telehealth Services Copayment **Orange Plan** **$20** for covered telehealth services received from PPO practitioners.
Yellow Plan **$30** for covered telehealth services received from PPO practitioners.
Urgent Care Center Copayment **Orange Plan** **$20** for covered services received from PPO Providers in Iowa or South Dakota classified by Wellmark as Urgent Care Centers and covered urgent care services received from PPO urgent care facilities or clinics outside of Iowa or South Dakota.†
Yellow Plan **$30** for covered services received from PPO Providers in Iowa or South Dakota classified by Wellmark as Urgent Care Centers and covered urgent care services received from PPO urgent care facilities or clinics outside of Iowa or South Dakota.†
Coinsurance **Orange Plan** **20%** for covered services received from PPO Providers. **20%** for covered self-administered injectable drugs. **30%** for covered chiropractic services received from PPO Providers. **30%** for covered services received from Participating and Out-of-Network providers. **40%** for covered chiropractic services received from Participating and Out-of-Network providers. **50%** for covered hearing aids.
Yellow Plan **20%** for covered services received from PPO Providers. **20%** for covered self-administered injectable drugs. **30%** for covered chiropractic services received from PPO Providers. **40%** for covered services received from Participating and Out-of-Network providers. **50%** for covered chiropractic services received from Participating and Out-of-Network providers. **50%** for covered hearing aids.
Out-of-Pocket Maximum **Orange Plan** **$2,000** per person for covered services received from PPO and Participating providers. **$4,000** (maximum) per family* for covered services received from PPO and Participating providers. **$4,000** per person for covered services received from Out-of-Network Providers. **$8,000** (maximum) per family* for covered services received from Out-of-Network Providers.
Yellow Plan **$4,000** per person for covered services received from PPO and Participating providers. **$8,000** (maximum) per family* for covered services received from PPO and Participating providers. **$8,000** per person for covered services received from Out-of-Network Providers. **$16,000** (maximum) per family* for covered services received from Out-of-Network Providers.

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

†For a list of Iowa or South Dakota facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.

Prescription Drugs

You Pay†
Coinsurance
20% for Tier 1 medications. **30%** for Tier 2 medications. **40%** for Tier 3 medications. For more information see *Tiers*, page 68. **20%** for preferred biosimilar or generic specialty drugs. **30%** for preferred brand specialty drugs. **40%** for non-preferred specialty drugs. **20%** for pharmacy durable medical equipment devices.
Out-of-Pocket Maximum
$3,600 per person **$7,200** (maximum) per family*

*Family amounts are reached from amounts accumulated on behalf of any combination of covered family members.
†You pay the entire cost if you purchase a drug or pharmacy durable medical equipment device that is not on the Wellmark Blue Rx Value Plus Drug List. See *Wellmark Blue Rx Value Plus Drug List*, page 36.

Prescription Maximums

Generally, there is a maximum days' supply of medication you may receive in a single prescription. However, exceptions may be made for certain prescriptions packaged in a dose exceeding the maximum days' supply covered under your Blue Rx Value Plus prescription drug benefits. To determine if this exception applies to your prescription, call the Customer Service number on your ID card.

Your payment obligations may be determined by the quantity of medication you purchase.

Prescription Maximum
90 day retail
90 day mail order
30 day specialty

Payment Details

Medical

Deductible

This is a fixed dollar amount you pay for covered services in a benefit year before medical benefits become available.

The family deductible amount is reached from amounts accumulated on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single deductible before we make benefit payments for that member.

Deductible amounts you pay for PPO or Participating and Out-of-Network provider services apply toward meeting both the PPO and the Participating/Out-of-Network deductibles. The maximum deductible amount you pay is the Participating/Out-of-Network deductible.

Once you meet the deductible, then coinsurance applies.

Common Accident Deductible. When two or more covered family members are involved in the same accident and they receive covered services for injuries related

to the accident, only one deductible amount will be applied to the accident-related services for all family members involved. However, you still need to satisfy the family (not the per person) out-of-pocket maximum.

When the No Surprises Act applies, you may not be required to satisfy your entire deductible before we make benefit payments, amounts you pay for items and services will accumulate toward your PPO deductible, and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Deductible amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Copayment

This is a fixed dollar amount that you pay each time you receive certain covered services.

Emergency Room Copayment.

The emergency room copayment:

- applies to emergency room facility services.
- is taken once per date of service.
- is waived if you are admitted as an inpatient of a facility immediately following emergency room services.

Practitioner services in an emergency room setting are subject to deductible and coinsurance and not this copayment.

Office Visit Copayment.

The office visit copayment:

- applies to the office exam only received from PPO practitioners.
- is taken once per date of service.

The office visit copayment does not apply to:

- chiropractic services.
- cochlear devices and related services.

These services are subject to deductible and coinsurance and not this copayment.

Related office services are subject to deductible and coinsurance and not this copayment.

Telehealth Services Copayment.

The telehealth services copayment:

- applies to covered telehealth services received from PPO practitioners.
- is taken once per date of service.

Urgent Care Center Copayment.

The urgent care center copayment:

- applies to the exam only received from:
  - PPO Providers in Iowa or South Dakota classified by Wellmark as Urgent Care Centers.
  - PPO urgent care facilities or clinics outside of Iowa or South Dakota.
- is taken once per date of service.

Please note: If you receive care at a facility in Iowa or South Dakota that is not classified by Wellmark as an Urgent Care Center, you may be responsible for your deductible and coinsurance (as applicable) instead of the urgent care center copayment. Therefore, before receiving any urgent care services, you should determine if the facility is classified by Wellmark as an Urgent Care Center. See the Wellmark Provider Directory at *Wellmark.com* or call the Customer Service number on your ID card to determine whether a facility is classified by Wellmark as an Urgent Care Center.

Related urgent care services are subject to deductible and coinsurance and not this copayment.

Copayment amount(s) are waived for some services. See *Waived Payment Obligations* later in this section.

Coinsurance

Coinsurance is an amount you pay for certain covered services. Coinsurance is

calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance is Calculated*, page 63. Coinsurance amounts apply after you meet the deductible.

Coinsurance amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum amount you pay, out of your pocket, for most covered services in a benefit year. Many amounts you pay for covered services during a benefit year accumulate toward the out-of-pocket maximum. These amounts include:

- Deductible.
- Certain coinsurance amounts.
- Emergency room copayments.
- Office visit copayments.
- Telehealth services copayments.
- Urgent care center copayments.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single out-of-pocket maximum.

There is an out-of-pocket maximum for services you receive from PPO Providers and Participating Providers. There is also an out-of-pocket maximum for services you receive from Out-of-Network Providers. These out-of-pocket maximums accumulate to one another.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.
- Coinsurance amounts you pay for hearing aids.
- Difference in cost between the provider's amount charged and our maximum allowable fee when you receive services from an Out-of-Network Provider.
- The amount of the reduction in plan benefits attributable to a member who is eligible for but has not enrolled in Medicare Part B coverage.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

These amounts continue even after you have met your out-of-pocket maximum.

When the No Surprises Act applies, amounts you pay for items and services will accumulate toward your PPO out-of-pocket maximum and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Benefits Maximums

Benefits maximums are the maximum benefit amounts that each member is eligible to receive.

Benefits maximums that apply per benefit year or per lifetime are reached from benefits accumulated under this group health plan and any prior group health plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

No Surprises Act

When the No Surprises Act applies, the amount you pay will be determined in

accordance with the Act and you may not be billed for more than the amount you would pay if the services had been provided by a Participating Provider. The No Surprises Act typically applies to emergency services at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

Waived Payment Obligations

To understand your complete payment obligations you must become familiar with this entire summary plan description. Most information on coverage and benefits maximums will be found in the *At a Glance – Covered and Not Covered* and *Details – Covered and Not Covered* sections.

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Breast pumps (manual or non-hospital grade electric) purchased from a covered home/durable medical equipment provider.	Deductible Coinsurance Copayment
Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, during pregnancy and/or the duration of breastfeeding.	Deductible Coinsurance Copayment
Contraceptive medical devices, such as intrauterine devices and diaphragms.	Deductible Coinsurance Copayment
Hearing aids.	Deductible
Implanted and injected contraceptives.	Deductible Coinsurance Copayment
Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.	Deductible Coinsurance Copayment
Mental health conditions and chemical dependency treatment – office and urgent care exams received from PPO Providers.	Deductible Coinsurance Copayment

Covered Service	Payment Obligation Waived
Preventive care, items, and services* as follows: ■ Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP); ■ Preventive care and screenings for infants, children, and adolescents provided for in guidelines supported by the Health Resources and Services Administration (HRSA); and ■ Preventive care and screenings for women provided for in guidelines supported by the HRSA.***	Deductible Coinsurance Copayment
Services subject to emergency room copayment amounts.	Deductible Coinsurance
Services subject to office visit copayment amounts.	Deductible Coinsurance
Services subject to telehealth services copayment amounts.	Deductible Coinsurance
Services subject to urgent care center copayment amounts.	Deductible Coinsurance
Telehealth services received from practitioners contracting through Doctor on Demand.‡	Deductible Coinsurance Copayment
Voluntary sterilization.	Deductible Coinsurance Copayment

*A complete list of recommendations and guidelines related to preventive services can be found at *www.healthcare.gov*. Recommended preventive services are subject to change and are subject to medical management. USPSTF "A" and "B" recommendations will be implemented no later than the first plan year that begins on or after the date that is one year after the USPSTF recommendations are issued. A USPSTF recommendation is considered to be issued on the last day of the month on which it publishes or otherwise releases the recommendation. Waived Payment Obligations will be effective following implementation of the USPSTF recommendation.

***Digital breast tomosynthesis (3D mammogram) may be subject to deductible, coinsurance, and copayments, as applicable.

‡Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

Prescription Drugs

Coinsurance

Coinsurance is the amount you pay, calculated using a fixed percentage of the maximum allowable fee, each time certain covered prescriptions subject to coinsurance are filled or refilled.

You pay the entire cost if you purchase a drug or pharmacy durable medical equipment device that is not on the Wellmark Blue Rx Value Plus Drug List. See *Wellmark Blue Rx Value Plus Drug List,* page 36.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum you pay in a given benefit year toward the following amounts:

- Coinsurance.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any combination of covered family members.

A member will not be required to satisfy more than the single out-of-pocket maximum.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

These amounts continue even after you have met your out-of-pocket maximum.

Waived Payment Obligations

To understand your complete payment obligations you must become familiar with this entire summary plan description. Most information on coverage and benefits maximums will be found in the *Details – Covered and Not Covered* section.

Some payment obligations are waived for the following covered drugs or services.

Covered Drug or Service	Payment Obligation Waived
Generic contraceptive drugs and generic contraceptive drug delivery devices (e.g., birth control patches). Payment obligations are also waived if you purchase brand name contraceptive drugs or brand name drug delivery devices when an FDA-approved medically appropriate generic equivalent is not available. Payment obligations are not waived if you purchase brand name contraceptive drugs or brand name contraceptive drug delivery devices when an FDA-approved medically appropriate generic equivalent is available.	Coinsurance

Covered Drug or Service	Payment Obligation Waived
Preventive items or services* as follows: ■ Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF); and ■ Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP).	Coinsurance
Two smoking cessation attempts per calendar year, up to a 90-days' supply of covered drugs for each attempt, or a 180-days' supply total per calendar year.	Coinsurance

*A complete list of recommendations and guidelines related to preventive services can be found at *www.healthcare.gov*. Recommended preventive items and services are subject to change and are subject to medical management.

B. At a Glance - Covered and Not Covered

Medical

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this summary plan description. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 17. To fully understand which services are covered and which are not, you must become familiar with this entire summary plan description. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

Category. Service categories are listed alphabetically and are repeated, with additional detailed information, in *Details – Covered and Not Covered*.

Covered. The listed category is generally covered, but some restrictions may apply.

Not Covered. The listed category is generally not covered.

See Page. This column lists the page number in *Details – Covered and Not Covered* where there is further information about the category.

Benefits Maximums. This column lists maximum benefit amounts that each member is eligible to receive. Benefits maximums that apply per benefit year or per lifetime are reached from benefits accumulated under this group health plan and any prior group health plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Category	Covered	Not Covered	See Page	Benefits Maximums
Acupuncture Treatment		⦸	17	
Allergy Testing and Treatment	●		17	
Ambulance Services	●		17	
Anesthesia	●		18	
Autism Treatment	●		18	
Blood and Blood Administration	●		18	
Chemical Dependency Treatment	●		18	
Chemotherapy and Radiation Therapy	●		19	
Clinical Trials – Routine Care Associated with Clinical Trials	●		19	
Contraceptives	●		19	
Conversion Therapy		⦸	20	
Cosmetic Services		⦸	20	

Category	Covered	Not Covered	See Page	Benefits Maximums
Counseling and Education Services	●		20	
Dental Treatment for Accidental Injury	●		20	
Dialysis	●		21	
Education Services for Diabetes and Nutrition	●		21	
Emergency Services	●		21	
Fertility Services	●		22	
Genetic Testing	●		22	
Hearing Services	●		22	One routine hearing examination per benefit year. $2,500 every 36 months for hearing aids.
Home Health Services	●		22	The daily benefit for extended home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services. The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for skilled nursing facility services. 100 days per benefit year for home health services combined with outpatient hospice care. 21 days per benefit year for extended home skilled nursing services.
Home/Durable Medical Equipment	●		23	
Hospice Services	●		24	185 days per benefit year for inpatient hospice care. 100 days per benefit year for outpatient hospice care combined with home health care.
Hospitals and Facilities	●		24	60 days per benefit year of skilled nursing services in a hospital or nursing facility.
Illegal Acts		⦸	25	
Illness or Injury Services	●		25	
Infertility Treatment		⦸	25	
Inhalation Therapy	●		26	
Maternity Services	●		26	
Medical and Surgical Supplies and Personal Convenience Items	●		26	
Mental Health Services	●		27	
Motor Vehicles		⦸	28	
Musculoskeletal Treatment	●		28	26 visits per benefit year for chiropractic services.
Nonmedical or Administrative Services		⦸	28	
Nutritional and Dietary Supplements	●		28	

Category	Covered	Not Covered	See Page	Benefits Maximums
Occupational Therapy	●		28	
Orthotics (Foot)	●		29	
Physical Therapy	●		29	
Physicians and Practitioners			29	
Advanced Registered Nurse Practitioners	●		29	
Audiologists	●		29	
Chiropractors	●		29	
Doctors of Osteopathy	●		29	
Licensed Independent Social Workers	●		29	
Licensed Marriage and Family Therapists	●		29	
Licensed Mental Health Counselors	●		29	
Medical Doctors	●		29	
Occupational Therapists	●		29	
Optometrists	●		30	
Oral Surgeons	●		30	
Physical Therapists	●		30	
Physician Assistants	●		30	
Podiatrists	●		30	
Psychologists	●		30	
Speech Pathologists	●		30	
Podiatry	●		30	
Prescription Drugs	●		31	
Preventive Care	●		32	Well-child care until the child reaches age 17. One routine physical examination per benefit year. One routine mammogram per benefit year. One routine gynecological examination per benefit year.
Prosthetic Devices	●		33	
Reconstructive Surgery	●		33	
Self-Help Programs		⦸	33	
Sleep Apnea Treatment	●		33	
Social Adjustment		⦸	33	
Speech Therapy	●		33	
Surgery	●		34	
Telehealth Services	●		34	

Category	Covered	Not Covered	See Page	Benefits Maximums
Temporomandibular Joint Disorder (TMD)	●		34	
Transplants	●		34	$5,000 per hospitalization for costs associated with organ donor expenses.
Travel or Lodging Costs		⦸	35	
Vision Services (related to an illness or injury)	●		35	
Wigs or Hairpieces		⦸	35	
X-ray and Laboratory Services	●		35	

Prescription Drugs

Please note: To determine if a drug is covered, you must consult the Wellmark Blue Rx Value Plus Drug List. You are covered for drugs listed on the Wellmark Blue Rx Value Plus Drug List. If a drug is not on the Wellmark Blue Rx Value Plus Drug List, it is not covered.

For details on drug coverage, drug limitations, and drug exclusions, see the next section, *Details – Covered and Not Covered*.

C. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this summary plan description. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 41. If a service or supply is not specifically listed, do not assume it is covered.

Medical

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered:

- Professional emergency air and ground ambulance transportation to a hospital in the surrounding area where your ambulance transportation originates.

  All of the following are required to qualify for benefits:

  — The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.

  — You are transported to the nearest hospital with adequate facilities to treat your medical condition.

  — During transport, your medical condition requires the services that are provided only by an air or ground ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility in an emergency.

  — The air or ground ambulance has the necessary patient care equipment and supplies to meet your needs.

  — Your medical condition requires immediate and rapid ambulance transport.

  — In addition to the preceding requirements, for air ambulance services to be covered, all of the following must be met:

    - Your medical condition requires immediate and rapid air ambulance transport that cannot be provided by a ground ambulance; or the point of pick up is inaccessible by a land vehicle.
    - Great distances, limited time frames, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment.
    - Your condition is such that the time needed to transport you by land poses a threat to your health.

When the No Surprises Act applies to air ambulance services, you cannot be billed for the difference between the amount charged and the total amount paid by us.

In an emergency situation, if you cannot reasonably utilize a PPO ambulance service, covered services will be reimbursed as though they were received from a PPO ambulance service. However, if ground ambulance services are provided by an Out-of-Network Provider, and because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you may be responsible for any difference between the amount charged and our amount paid for a

covered service. When receiving ground ambulance services, select a provider who participates in your network to avoid being responsible for any difference between the billed charge and our settlement amount.

- Professional non-emergency ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

  All of the following are required to qualify for benefits:

  — The services required to treat your illness or injury are not available in the facility where you are currently receiving care.
  — You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.
  — During transport your medical condition requires the services that are provided only by a ground ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility.
  — The ground ambulance has the necessary patient care equipment and supplies to meet your needs.

Not Covered:

- Professional air or ground ambulance transport from a facility capable of treating your condition.
- Professional ground ambulance transport to or from any location when you are physically and mentally capable of being a passenger in a private vehicle.
- Professional ground ambulance round-trip transports from your residence to a medical provider for an appointment or treatment and back to your residence.
- Professional air or ground transport when performed primarily for your convenience or the convenience of your family, physician, or other health care provider.
- Professional, non-emergency air ambulance transports to any location for any reason.
- Nonprofessional air or ground ambulance transports to any location for any reason. This includes non-ambulance vehicles such as vans or taxis that are equipped to transport stretchers or wheelchairs but are not professionally operated or staffed.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Autism Spectrum Disorder Treatment

Covered: Diagnosis and treatment of autism spectrum disorder and Applied Behavior Analysis services for the treatment of autism spectrum disorder when Applied Behavior Analysis services are performed or supervised by a licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board certified behavior analyst.

Blood and Blood Administration

Covered: Blood and blood administration, including blood derivatives, and blood components.

Chemical Dependency Treatment

Covered: Treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs or alcohol as described in the most current *Diagnostic and Statistical Manual of Mental Disorders*.

Licensed Substance Abuse Treatment Program. Benefits are available for

chemical dependency treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Drug or alcohol rehabilitation therapy or counseling provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Treatment provided in a medically monitored intensive inpatient or detoxification setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered:

- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in substance abuse treatment programs.

See Also:

Hospitals and Facilities later in this section.

Notification Requirements and Care Coordination, page 55.

Chemotherapy and Radiation Therapy

Covered: Use of chemical agents or radiation to treat or control a serious illness.

Clinical Trials – Routine Care Associated with Clinical Trials

Covered: Medically necessary routine patient costs for items and services otherwise covered under this plan furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when a covered member is referred by a PPO or Participating provider based on the conclusion that the member is eligible to participate in an approved clinical trial according to the trial protocol or the member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate according to the trial protocol.

Not Covered:

- Investigational or experimental items, devices, or services which are themselves the subject of the clinical trial;
- Clinical trials, items, and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Contraceptives

Covered: The following conception prevention, as approved by the U.S. Food and Drug Administration:

- Contraceptive medical devices, such as intrauterine devices and diaphragms.
- Implanted contraceptives.
- Injected contraceptives.

Please note: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches are covered

under your Blue Rx Value Plus prescription drug benefits described later in this section.

See the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com* or call the Customer Service number on your ID card and request a copy of the Drug List.

Conversion Therapy

Not Covered: Conversion therapy services.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. However, a service, supply, or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling and Education Services

Covered:

- Bereavement counseling or services.
- Family or marriage counseling or services.

Not Covered:

- Community-based services or services of volunteers or clergy.
- Education or educational therapy other than covered lactation consultant services, education for self-management of diabetes, or nutrition education.
- Learning and educational services and treatments including, but not limited to, non-drug therapy for high blood pressure control, exercise modalities for weight reduction, nutritional instruction for the control of gastrointestinal conditions, or reading programs for dyslexia for any medical, mental health, or substance abuse condition.
- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

See Also:

Genetic Testing later in this section.

Education Services for Diabetes and Nutrition later in this section.

Mental Health Services later in this section.

Preventive Care later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an outpatient. Inpatient removal is covered only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.

- Jaw dislocation manipulation.
- Orthodontic services associated with management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease of the mouth, or dental care (oral examination, x-rays, extractions, and nonsurgical elimination of oral infection) required for the direct treatment of a medical condition, limited to:
  - Dental services related to medical transplant procedures;
  - Initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); or
  - Treatment of neoplasms of the mouth and contiguous tissue.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or management of cleft palate.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes and Nutrition

Covered: Inpatient and outpatient training and education for the self-management of all types of diabetes mellitus when received from a PPO Provider.

All covered training or education must be prescribed by a licensed physician. Outpatient training or education must be provided by a state-certified program.

The state-certified diabetic education program helps any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.

You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your nutritional requirements. Nutrition education is appropriate for the following conditions:

- Cancer.
- Cystic fibrosis.
- Diabetes.
- Eating disorders.
- Glucose intolerance.
- High blood pressure.
- High cholesterol.
- Lactose intolerance.
- Malabsorption, including gluten intolerance.
- Obesity.
- Underweight.

Not Covered: Inpatient and outpatient training and education for the self-management of all types of diabetes mellitus when received from a Participating or Out-of-Network provider.

Emergency Services

Covered: When treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or

- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a PPO Provider, covered services will be reimbursed as though they were received from a PPO Provider. When the No Surprises Act applies to emergency services, you cannot be billed for the difference between the amount charged and the total amount paid by us.

See Also:

Out-of-Network Providers, page 65.

Fertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).

Not Covered:

- Abortion that is elective (except abortions performed when the life of the mother is at risk if the pregnancy goes to full term and complications resulting from a noncovered abortion).

Genetic Testing

Covered: Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

Hearing Services

Covered:

- Routine hearing examinations.
- Hearing aids.
- Cochlear implants.

Benefits Maximum:

- **One** routine hearing examination per benefit year.
- **$2,500** every 36 months for hearing aids.

Home Health Services

Covered: All of the following requirements must be met in order for home health services to be covered:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by Wellmark for the treatment of illness or injury.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.

The following are covered services and supplies:

Extended Home Skilled Nursing. Home skilled nursing care, other than short-term home skilled nursing, provided in the home by a registered (R.N.) or licensed practical nurse (L.P.N.) who is associated with an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency that is ordered by a physician and consists of four or more hours per day of continuous nursing care that requires the technical proficiency and knowledge of an R.N. or L.P.N. The daily benefit for extended home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Benefits do not include custodial care or services

provided for the convenience of the family caregiver.

Home Health Aide Services—when provided in conjunction with a medically necessary skilled service also received in the home.

Short-Term Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Short-term home skilled nursing means home skilled nursing care that:

- is provided for a definite limited period of time as a safe transition from other levels of care when medically necessary;
- provides teaching to caregivers for ongoing care; or
- provides short-term treatments that can be safely administered in the home setting.

The daily benefit for short-term home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition, except enteral formula administered orally.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Devices and Braces.

Speech Therapy.

Benefits Maximum:

- **100 days** per benefit year for home health services and outpatient hospice care.
- **21 days** per benefit year for extended home skilled nursing services.

Not Covered:

- Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitaria care or rest cures.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- The equipment is ordered by a provider within the scope of his or her license and there is a written prescription.
- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

- Standard or basic home/durable medical equipment that will adequately meet the medical needs and that does not have certain deluxe/luxury or convenience upgrade or add-on features.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Benefits will never exceed the lesser of the amount charged or the maximum allowable fee.

See Also:

Medical and Surgical Supplies and Personal Convenience Items later in this section.

Orthotics (Foot) later in this section.

Prosthetic Devices later in this section.

Hospice Services

Covered: Care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice care covers the same services as described under *Home Health Services*, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital.

Benefits Maximum:

- **185 days** per benefit year for inpatient hospice care.
- **100 days** per benefit year for outpatient hospice care and home health care.

Hospitals and Facilities

Covered: Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed and must be licensed as an ambulatory surgical facility under applicable law.

Chemical Dependency Treatment Facility. This type of facility must be licensed as a chemical dependency treatment facility under applicable law.

Community Mental Health Center. This type of facility provides treatment of mental health conditions and must be licensed as a community mental health center under applicable law.

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.

Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis for short-term care. Benefits do not include maintenance or custodial care or services provided for the convenience of the family caregiver. The facility must be licensed as a nursing facility under applicable law.

Psychiatric Medical Institution for Children (PMIC). This type of facility provides inpatient psychiatric services to children and is licensed as a PMIC under Iowa Code Chapter 135H.

Benefits Maximum:

- **60 days** per benefit year for skilled nursing services in a hospital or nursing facility.

Not Covered:

- Long Term Acute Care Facility.
- Room and board provided while a patient at an intermediate care facility or similar level of care.

Please note:

When the No Surprises Act applies to items and services from an Out-of-Network Provider at a participating facility, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no Participating Provider who can furnish such item or service at such facility.

See Also:

Chemical Dependency Treatment earlier in this section.

Mental Health Services later in this section.

Illegal Acts

Not Covered: Charges for care, supplies, treatment, and/or services for any injury or sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or if filed, that a conviction results. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion shall not apply if the injury or sickness resulted from being a victim of an act of domestic violence or a medical condition (including both physical and mental health conditions).

Illness or Injury Services

Covered:

- Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.
- Routine foot care related to the treatment of a metabolic, neurological, or peripheral vascular disease.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor's office).
- Outpatient.

Not Covered:

- Long term acute care services typically provided by a long term acute care facility.
- Room and board provided while a patient at an intermediate care facility or similar level of care.

Infertility Treatment

Not Covered:

- Infertility diagnosis and treatment.
- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing and storage of sperm, oocytes, or embryos; surrogate parent services.

- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Inhalation Therapy

Covered: Respiratory or breathing treatments to help restore or improve breathing function.

Maternity Services

Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

Please note: You must notify us or your employer or group sponsor if you enter into an arrangement to provide surrogate parent services: Contact your employer or group sponsor or call the Customer Service number on your ID card.

In accordance with federal or applicable state law, maternity services include a minimum of:

- 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery, or
- 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

Coverage includes one follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

Not Covered: Maternity services for dependent children (with the exception of complications of pregnancy).

See Also:

Coverage Change Events, page 83.

Medical and Surgical Supplies and Personal Convenience Items

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies purchased from a covered provider.

Not Covered: Unless otherwise required by law, supplies, equipment, or drugs available for general retail purchase or items used for your personal convenience including, but not limited to:

- Band-aids, gauze, bandages, tape, non-sterile gloves, thermometers, heating pads, cooling devices, cold packs, heating devices, hot water bottles, home enema equipment, sterile water, bed boards, alcohol wipes, or incontinence products;
- Elastic stockings or bandages including lumbar braces, garter belts, and similar items that can be purchased without a prescription;
- Escalators, elevators, ramps, stair glides, emergency/alert equipment, handrails, heat appliances, improvements made to a member's house or place of business, or adjustments made to vehicles;
- Household supplies including, but not limited to: deluxe/luxury equipment or non-essential features, such as motor-driven chairs or bed, electric stair chairs or elevator chairs, or sitz bath;

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury including, but not limited to, air conditioners, hot tubs, or swimming pools;
- Items that do not serve a medical purpose or are not needed to serve a medical purpose;
- Rental or purchase of equipment if you are in a facility which provides such equipment;
- Rental or purchase of exercise cycles, physical fitness, exercise and massage equipment, ultraviolet/tanning equipment, or traction devices; and
- Water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool, spa, air purifiers, humidifiers, dehumidifiers, or light devices.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics (Foot) later in this section.

Prescription Drugs, page 35.

Prosthetic Devices later in this section.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Covered facilities for mental health services include licensed and accredited residential treatment facilities and community mental health centers.

To qualify for mental health treatment benefits, the following requirements must be met:

- The disorder is classified as a mental health condition in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) or subsequent revisions, except as otherwise provided in this summary plan description.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of *International Classification of Diseases, Clinical Modification* used for diagnosis coding.

Licensed Psychiatric or Mental Health Treatment Program Services. Benefits are available for mental health treatment in the following settings:

- Treatment provided in an office visit, or outpatient setting;
- Treatment provided in an intensive outpatient setting;
- Treatment provided in an outpatient partial hospitalization setting;
- Individual, group, or family therapy provided in a clinically managed low intensity residential treatment setting, also known as supervised living;
- Treatment, including room and board, provided in a clinically managed medium or high intensity residential treatment setting;
- Psychiatric observation;
- Care provided in a psychiatric residential crisis program;
- Care provided in a medically monitored intensive inpatient setting; and
- For inpatient, medically managed acute care for patients whose condition requires the resources of an acute care general hospital or a medically managed inpatient treatment program.

Not Covered: Treatment for:

- Biofeedback.
- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders.
- Conditions that are not pervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual disorders.

- Room and board provided while participating in a clinically managed low intensity residential treatment setting, also known as supervised living.
- Recreational activities or therapy, social activities, meals, excursions or other activities not considered clinical treatment, while participating in residential psychiatric treatment programs.

See Also:

Chemical Dependency Treatment and *Hospitals and Facilities* earlier in this section.

Motor Vehicles

Not Covered: Purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Musculoskeletal Treatment

Covered: Outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Benefits Maximum:

- **26 visits** per benefit year for chiropractic services.

Not Covered:

- Manipulations or related procedures to treat musculoskeletal injury or disease performed for maintenance.
- Massage therapy.

Nonmedical or Administrative Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Nutritional and Dietary Supplements

Covered:

- Nutritional and dietary supplements that cannot be dispensed without a prescription issued by or authorized by a licensed healthcare practitioner and are prescribed by a licensed healthcare practitioner for permanent inborn errors of metabolism, such as PKU.
- Enteral and nutritional therapy only when prescribed feeding is administered through a feeding tube, except for permanent inborn errors of metabolism.

Not Covered: Other prescription and non-prescription nutritional and dietary supplements including, but not limited to:

- Food products.
- Grocery items or food products that are modified for special diets for individuals with inborn errors of metabolism but which can be purchased without a prescription issued by or authorized by a licensed healthcare practitioner, including low protein/low phe grocery items.
- Herbal products.
- Fish oil products.
- Medical foods, except as described under *Covered*.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

Occupational Therapy

Covered: Occupational therapy services are covered when all the following requirements are met:

- Services are to treat the upper extremities, which means the arms from the shoulders to the fingers.

- The goal of the occupational therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation or habilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Occupational therapy performed for maintenance.
- Occupational therapy services that do not meet the requirements specified under *Covered*.

Orthotics (Foot)

Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such devices, and orthotics training.

See Also:

Home/Durable Medical Equipment earlier in this section.

Prosthetic Devices later in this section.

Physical Therapy

Covered: Physical therapy services are covered when all the following requirements are met:

- The goal of the physical therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation or habilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered:

- Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.
- Physical therapy performed for maintenance.
- Physical therapy services that do not meet the requirements specified under *Covered*.

Physicians and Practitioners

Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

Advanced Registered Nurse Practitioners (ARNP). An ARNP is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.

Audiologists.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Licensed Marriage and Family Therapists.

Licensed Mental Health Counselors.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating

the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists.

Oral Surgeons.

Physical Therapists.

Physician Assistants.

Podiatrists.

Psychologists. Psychologists must have a doctorate degree in psychology with two years' clinical experience and meet the standards of a national register.

Speech Pathologists.

See Also:

Choosing a Provider, page 47.

Podiatry

Covered:

- Routine foot care including removal of corns, ingrown toenails, calluses, and warts.
- Orthopedic care of structural foot problems including strapping, casting, or fitting of orthotics.

Prescription Drugs

Covered: Most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," are generally covered under your Blue Rx Value Plus prescription drug benefits, not under your medical benefits. However, there are exceptions when prescription drugs and medicines are covered under your medical benefits.

Drugs classified by the FDA as Drug Efficacy Study Implementation (DESI) drugs may also be covered. For a list of these drugs, visit our website at *Wellmark.com* or check with your pharmacist or physician.

Drugs listed on the Drug List are established and maintained by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is a group of independent practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety, effectiveness, and value of new and existing medications and make any necessary changes to the coverage of medications. Drugs will not be covered until they have been evaluated and approved to be covered by Wellmark's P&T Committee. Drugs previously approved by Wellmark's P&T Committee will no longer be covered if Wellmark's P&T Committee discontinues approval of the drugs.

Prescription drugs and medicines that may be covered under your medical benefits include:

Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

Specialty Drugs. Specialty drugs are high-cost injectable, infused, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. They are not available through the mail order drug program.

Specialty drugs may be covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits. If a specialty drug that is covered under your medical benefits is not provided by your physician, you must purchase specialty drugs through the specialty pharmacy program. To determine whether a particular specialty drug is covered under your medical benefits or under your Blue Rx Value Plus prescription drug benefits, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card. See *Specialty Pharmacy Program*, page 54.

You are not covered for specialty drugs purchased outside the specialty pharmacy program unless the specialty drug is covered under your medical benefits.

Take-Home Drugs. Take-home drugs are drugs dispensed and billed by a hospital or other facility for a short-term supply.

Not Covered: Some prescription drugs, services, and items are not covered under either your medical benefits or your Blue Rx Value Plus benefits. For example:

- Antigen therapy.

- Medication Therapy Management (MTM) when billed separately.
- Drugs purchased outside the United States failing the requirements specified earlier in this section.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.
- Prescription drugs or pharmacy durable medical equipment devices that are not FDA-approved.
- Prescription drugs that are not approved to be covered by Wellmark's P&T Committee.
- Growth hormones.

Some prescription drugs are covered under your Blue Rx Value Plus benefits:

- Insulin.

See the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com* or call the Customer Service number on your ID card and request a copy of the Drug List.

See Also:

Contraceptives earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Notification Requirements and Care Coordination, page 55.

Prescription Drugs later in this section.

Prior Authorization, page 60.

Preventive Care

Covered: Preventive care such as:

- Breastfeeding support, supplies, and one-on-one lactation consultant services, including counseling and education, provided during pregnancy and/or the duration of breastfeeding received from a provider acting within the scope of their licensure or certification under state law.
- Digital breast tomosynthesis (3D mammogram).
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
  - Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP);
  - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
  - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including immunizations.

Benefits Maximum:

- Well-child care until the child reaches age 17.
- **One** routine physical examination per benefit year.
- **One** routine mammogram per benefit year.
- **One** routine gynecological examination per benefit year.

Please note: Physical examination limits do not include items or services with an "A" or "B" rating in the current recommendations of the USPSTF, immunizations as recommended by ACIP,

and preventive care and screening guidelines supported by the HRSA, as described under *Covered*.

Not Covered:

- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel, or other administrative purposes.
- Group lactation consultant services.
- All treatment related to nicotine dependence, except as described under *Covered*. For prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician, please see your Blue Rx Value Plus prescription drug benefits.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Devices

Covered: Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

Also covered are braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

- Elastic stockings or bandages including, lumbar braces, garter belts, and similar items that can be purchased without a prescription.
- Penile prostheses.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies and Personal Convenience Items earlier in this section.

Orthotics (Foot) earlier in this section.

Reconstructive Surgery

Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:

Cosmetic Services earlier in this section.

Self-Help Programs

Not Covered: Self-help and self-cure products or drugs.

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

Not Covered: Treatment for snoring without a diagnosis of obstructive sleep apnea.

Social Adjustment

Not Covered: Services or supplies intended to address social adjustment or economic needs that are typically not medical in nature.

Speech Therapy

Covered: Rehabilitative or habilitative speech therapy services when related to a specific illness, injury, or impairment, including speech therapy services for the treatment of autism spectrum disorder, that involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered:

- Speech therapy services not provided by a licensed or certified speech pathologist.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

Surgery

Covered. This includes the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

Not Covered:

- Bariatric surgery or any bariatric-related surgery including, but not limited to, panniculectomy or other body contouring procedures.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Telehealth Services

Covered: You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification or by a practitioner contracting through Doctor on Demand via real-time, interactive audio-visual technology, web-based mobile device or similar electronic-based communication network, or as otherwise required by Iowa law. Services must be delivered in accordance with applicable law and generally accepted health care practices.

Please note: Members can access telehealth services from Doctor on Demand through the Doctor on Demand mobile application or through *myWellmark.com*.

Not Covered: Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Routine dental services, dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Covered:

- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Simultaneous pancreas/kidney.
- Small bowel.

You are also covered for the medically necessary expenses of transporting the recipient when the transplant organ for the recipient is available for transplant.

Transplants are subject to care management.

Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by your medical benefits.

Benefits Maximum:

- $5,000 per hospitalization for organ donor expenses.

Not Covered:

- Expenses of transporting the recipient when the transplant organ for the recipient is not available for transplant.
- Expenses of transporting a living donor.
- Expenses related to the purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services and supplies not listed in this section including complications.

See Also:

Ambulance Services earlier in this section.

Care Management, page 60.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered:

- Vision examinations but only when related to an illness or injury.
- Eyeglasses, but only when prescribed as the result of cataract extraction.
- Contact lenses and associated lens fitting, but only when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or corneal disease.

Not Covered:

- Surgery and services to diagnose or correct a refractive error, including intraocular lenses and laser vision correction surgery (e.g., LASIK surgery).
- Eyeglasses, contact lenses, or the examination for prescribing or fitting of eyeglasses or contact lenses, except when prescribed as the result of cataract extraction or when the underlying diagnosis is a corneal injury or disease.
- Eye exercises.
- Routine vision examinations.

Wigs or Hairpieces

Not Covered.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

Prescription Drugs

Guidelines for Drug Coverage

To be covered, a prescription drug or pharmacy durable medical equipment device must meet all of the following criteria:

- Listed on the Wellmark Blue Rx Value Plus Drug List.
- Can be legally obtained in the United States only with a written prescription.
- Deemed both safe and effective by the U.S. Food and Drug Administration (FDA) and approved for use by the FDA after 1962.
- Prescribed by a practitioner prescribing within the scope of his or her license.
- Dispensed by a recognized licensed participating retail pharmacy employing licensed registered pharmacists, through the specialty pharmacy program, through the mail order drug program, or dispensed and billed by a hospital or other facility as a take-home drug for a short-term supply.

- Medically necessary for your condition. See *Medically Necessary*, page 41.
- Not available in an equivalent over-the-counter strength. However, certain over-the-counter products and over-the-counter nicotine dependency drugs prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.
- Reviewed, evaluated, and recommended for addition to the Wellmark Blue Rx Value Plus Drug List by Wellmark.

Drugs that are Covered

The Wellmark Blue Rx Value Plus Drug List

The Wellmark Blue Rx Value Plus Drug List is a reference list that includes generic and brand-name prescription drugs and pharmacy durable medical equipment devices that have been approved by the U.S. Food and Drug Administration (FDA) and are covered under your Blue Rx Value Plus prescription drug benefits. The Wellmark Blue Rx Value Plus Drug List is established and maintained by Wellmark's Pharmacy & Therapeutics (P&T) Committee. The P&T Committee is an independent group of practicing healthcare providers such as physicians and pharmacists who regularly meet to review the safety, effectiveness, and value of new and existing medications and make any necessary changes to the Drug List. The Drug List is updated on a quarterly basis. Changes to the Drug List may occur more frequently, when new versions or generic versions of existing drugs become available, new safety concerns arise, and as discontinued drugs are removed from the marketplace. Additional changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier/level) occur semi-annually.

To determine if a drug is covered, you must consult the Wellmark Blue Rx Value Plus Drug List. You are covered for drugs listed on the Wellmark Blue Rx Value Plus Drug List. If a drug is not on the Wellmark Blue Rx Value Plus Drug List, it is not covered.

If you need help determining if a particular drug is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card and request a copy of the Drug List.

The Drug List is subject to change.

Preventive Items and Services

Preventive items and services received at a participating licensed retail pharmacy, including certain items or services recommended with an "A" or "B" rating by the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration are covered. To determine if a particular preventive item or service is covered, consult the Wellmark Blue Rx Value Plus Drug List or call the Customer Service number on your ID card.

Specialty Drugs

Specialty drugs are high-cost injectable, oral, or inhaled drugs typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. You must purchase specialty drugs through the specialty pharmacy program. They are not available through the mail order drug program.

Specialty drugs may be covered under your Blue Rx Value Plus prescription drug benefits or under your medical benefits. To determine whether a particular specialty drug is covered under your Blue Rx Value Plus prescription drug benefits or under your medical benefits, consult the Wellmark Blue Rx Value Plus Drug List at Wellmark.com, check with your pharmacist or physician, or call the Customer Service

number on your ID card. See *Specialty Pharmacy Program*, page 54.

Nicotine Dependency Drugs
Prescription drugs and devices used to treat nicotine dependence, including over-the-counter drugs prescribed by a physician are covered.

Benefits Maximum: 180-days' supply of covered over-the-counter drugs for smoking cessation per calendar year.

Where to Purchase Prescription Drugs

Participating Pharmacies. You must purchase prescription drugs and pharmacy durable medical equipment devices from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Drugs*, later in this section).

If you purchase drugs or pharmacy durable medical equipment devices from nonparticipating pharmacies, you are responsible for the entire cost of the drug or pharmacy durable medical equipment device. To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Specialty Drugs. You must purchase specialty drugs through the specialty pharmacy program. The specialty pharmacy program is limited to CVS Specialty®. If you purchase specialty drugs outside the specialty pharmacy program, you are responsible for the entire cost of the drug. See *Specialty Pharmacy Program*, page 54.

Limits on Prescription Drug Coverage

We may exclude, discontinue, or limit coverage for any drug by removing it from the Drug List or by moving a drug to a different tier on the Drug List for any of the following reasons:

- New drugs are developed.
- Generic drugs become available.
- Over-the-counter drugs with similar properties become available or a drug's active ingredient is available in a similar strength in an over-the-counter product or as a nutritional or dietary supplement product available over the counter.
- There is a sound medical reason.
- Scientific evidence does not show that a drug works as well and is as safe as other drugs used to treat the same or similar conditions.
- A drug receives FDA approval for a new use.

Drugs, Services, and Items that are Not Covered

Drugs, services, and items that are not covered under your prescription drug benefits include, but are not limited to:

- Drugs not listed on the Wellmark Blue Rx Value Plus Drug List.
- Drugs and pharmacy durable medical equipment devices purchased from nonparticipating pharmacies.
- Specialty drugs purchased outside the specialty pharmacy program unless the specialty drug is covered under your medical benefits.
- Drugs in excess of a quantity limitation. See *Quantity Limitations* later in this section.
- Antigen therapy.
- Drugs that are not FDA-approved.
- Drugs that are not approved to be covered by Wellmark's P&T Committee.
- Investigational or experimental drugs.
- Compounded drugs that do not contain an active ingredient in a form that has been approved by the FDA and that require a prescription to obtain.
- Compounded drugs that contain bulk powders or that are commercially available as a similar prescription drug.

- Drugs determined to be abused or otherwise misused by you.
- Drugs that are lost, damaged, stolen, or used inappropriately.
- Contraceptive medical devices, such as intrauterine devices and diaphragms. These are covered under your medical benefits. See *Contraceptives*, page 19.
- Convenience packaging. If the cost of the convenience packaged drug exceeds what the drug would cost if purchased in its normal container, the convenience packaged drug is not covered.
- Cosmetic drugs.
- Infused drugs. These may be covered under your medical benefits. See *Specialty Drugs*, page 31.
- Irrigation solutions and supplies.
- Medication Therapy Management (MTM) when billed separately.
- Therapeutic devices or medical appliances.
- Infertility drugs.
- Weight reduction drugs.
- Difference in cost between the generic drug and the brand name drug when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent.

See Also:

Prescription Drugs, page 31.

Prescription Purchases Outside the United States

To qualify for benefits for prescription drugs purchased outside the United States, all of the following requirements must be met:

- You are injured or become ill while in a foreign country.
- The prescription drug's active ingredient and dosage form are FDA-approved or an FDA equivalent and has the same name and dosage form as the FDA-approved drug's active ingredient.
- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician.

In addition, coverage for certain drugs is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs with quantity limits, check with your pharmacist or physician, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

Refills

To qualify for refill benefits, all of the following requirements must be met:

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your practitioner.
- The refill is not limited by state law.

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time.

If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the United States, the refill amount will not exceed a 90-day supply.

To receive authorization for an early refill, ask your pharmacist to call us.

D. General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

Conditions of Coverage

Medically Necessary
A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Wellmark's medically necessary analysis and determinations apply to any service, supply, device, or drug including, but not limited to, medical, mental health, and chemical dependency treatment, as appropriate. Even though a provider may recommend a service or supply, it may not be medically necessary.

A medically necessary health care service is one that a provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and satisfies all of the following criteria:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Nationally recognized utilization management standards as utilized by Wellmark; or
  - Wellmark's published Medical and Drug Policies as determined applicable by Wellmark; or
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease,
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

If you receive services that are not medically necessary, you are responsible for the cost if:

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a PPO or Participating provider in the Wellmark service area and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be not medically necessary; and
  - The provider gives you a written estimate of the cost for such services

and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the PPO or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Member Eligibility
Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 73.

General Exclusions

Even if a service, supply, device, or drug is listed as otherwise covered in *Details - Covered and Not Covered,* it is not eligible for benefits if any of the following general exclusions apply.

Investigational or Experimental
You are not covered for a service, supply, device, biological product, or drug that is investigational or experimental. You are also not covered for any care or treatments related to the use of a service, supply, device, biological product, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine. Our analysis of whether a service, supply, device, biological product, or drug is considered investigational or experimental is applied to medical, surgical, mental health, and chemical dependency treatment services, as applicable.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross Blue Shield Association, including whether a service, supply, device, biological product, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning its effect on health outcomes.
- It improves the net health outcome.
- It is as beneficial as any established alternatives.
- The health improvement is attainable outside the investigational setting.

These criteria are considered by the Blue Cross Blue Shield Association's Medical Advisory Panel for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other Blue Cross and Blue Shield member organizations. You may access our medical policies, with supporting information and selected medical references for a specific service, supply, device, biological product, or drug through our website, *Wellmark.com*.

If you receive services that are investigational or experimental, you are responsible for the cost if:

- You receive the services from an Out-of-Network Provider; or
- You receive the services from a PPO or Participating provider in the Wellmark service area and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to

be investigational or experimental; and

— The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the PPO or Participating provider is responsible for these amounts.

- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be investigational or experimental. This is true even if the provider does not give you any written notice before the services are rendered.

See Also:

Clinical Trials, page 19.

Complications of a Noncovered Service

You are not covered for a complication resulting from a noncovered service, supply, device, or drug. However, this exclusion does not apply to the treatment of complications resulting from:

- Smallpox vaccinations when payment for such treatment is not available through workers' compensation or government-sponsored programs; or
- A noncovered abortion.

Nonmedical or Administrative Services

You are not covered for telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, recreational therapy and other sensory-type activities, administrative services (such as interpretive services, pre-care assessments, health risk assessments, care management, care coordination, or development of treatment plans) when billed separately, and any services or supplies that are nonmedical.

Provider Is Family Member

You are not covered for a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner).

Covered by Other Programs or Laws

You are not covered for a service, supply, device, or drug if:

- Someone else has the legal obligation to pay for services, has an agreement with you to not submit claims for services or, without this group health plan, you would not be charged.
- Prescription drug claims are submitted to another insurance carrier. We will not reimburse you for amounts that are unpaid by your other carrier, including deductible, coinsurance, or copayments.
- You require services or supplies for an illness or injury sustained while on active military status.

Workers' Compensation

You are not covered for services or supplies for which we learn or are notified by you, your provider, or our vendor that such services or supplies are related to a work related illness or injury, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. We will comply with our statutory obligation regarding payment on claims on which workers' compensation liability is unresolved. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if:

- you did not comply with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization; or
- you rejected workers' compensation coverage.

The exclusion for services or supplies related to work related illness or injury does not exclude coverage for such illness or injury if you are exempt from coverage under Iowa's workers' compensation statutes pursuant to Iowa Code Section 85.1 (1)-(4), unless you or your employer has elected or obtained workers' compensation coverage as provided in Iowa Code Section 85.1(6).

For treatment of complications resulting from smallpox vaccinations, see *Complications of a Noncovered Service* earlier in this section.

Wellmark Medical and Drug Policies
Wellmark maintains Medical and Drug Policies that are applied in conjunction with other resources to determine whether a specific service, supply, device, biological product, or drug is a covered service under the terms of this summary plan description. These policies are hereby incorporated into this summary plan description. You may access these policies along with supporting information and selected medical references through our website, *Wellmark.com*.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this group health plan. These amounts are not credited toward your out-of-pocket maximum. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a benefits maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered,* page 17.
- If you do not obtain precertification for certain medical services, benefits can be reduced or denied. You are responsible for benefit reductions if you receive the services from an Out-of-Network Provider. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 55.
- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

  You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A PPO Provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO Provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 55.
- If you do not obtain prior authorization for certain prescription drugs, benefits can be denied. See *Notification Requirements and Care Coordination*, page 55.

- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 47, and *Factors Affecting What You Pay*, page 63. An example of a charge that depends on the type of provider includes, but is not limited to:
  - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from an Out-of-Network Provider.

E. Choosing a Provider

Medical

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers. Which provider type you choose will affect what you pay.

It relies on a preferred provider organization (PPO) network, which consists of providers that participate directly with the Wellmark Blue PPO network and providers that participate with other Blue Cross and/or Blue Shield preferred provider organizations (PPOs). These PPO Providers offer services to members of contracting medical benefits plans at a reduced cost, which usually results in the least expense for you.

Non-PPO providers are either Participating or Out-of-Network. If you are unable to utilize a PPO Provider, it is usually to your advantage to visit what we call a *Participating Provider*. Participating Providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a PPO.

Other providers are considered Out-of-Network, and you will usually pay the most for services you receive from them.

Note, however that when you receive services from certain types of Participating and Out-of-Network providers, those services will be reimbursed as though they were received from a PPO Provider. These providers are:

- Anesthesiologists;
- Pathologists; and
- Radiologists.

However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you will still be responsible for any difference between the billed charge and our settlement amount for the services from the Out-of-Network ancillary provider unless the No Surprises Act applies.

See *What You Pay,* page 3 and *Factors Affecting What You Pay,* page 63.

To determine if a provider participates with this medical benefits plan, ask your provider, refer to our online provider directory at *Wellmark.com*, or call the Customer Service number on your ID card.

Providers are independent contractors and are not agents or employees of Wellmark Blue Cross and Blue Shield of Iowa. For types of providers that may be covered under your medical benefits, see *Hospitals and Facilities*, page 24 and *Physicians and Practitioners*, page 29.

Please note: Even if a specific provider type is not listed as a recognized provider type, Wellmark does not discriminate against a licensed health care provider acting within the scope of his or her state license or certification with respect to coverage under this plan.

Please note: Even though a facility may be PPO or Participating, particular providers within the facility may not be PPO or Participating providers. Examples include Out-of-Network physicians on the staff of a PPO or Participating hospital, home medical equipment suppliers, and other independent providers. Therefore, when you are referred by a PPO or Participating provider to another provider, or when you are admitted into a facility, always ask if the providers contract with a Blue Cross and/or Blue Shield Plan.

Always carry your ID card and present it when you receive services. Information on

it, especially the ID number, is required to process your claims correctly.

Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. See *Choosing a Pharmacy* and *Specialty Pharmacy Program* later in this section.

Provider Comparison Chart	**PPO**	**Participating**	**Out-of-Network**
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	Yes	No
Minimizes your payment obligations. See *What You Pay*, page 3.	Yes	No	No
Claims are filed for you.	Yes	Yes	No
Blue Cross and/or Blue Shield pays these providers directly.	Yes	Yes	No
Notification requirements are handled for you.	Yes*	Yes*	No

*If you visit a PPO or Participating provider outside the Wellmark service area, you are responsible for notification requirements. See *Services Outside the Wellmark Service Area* later in this section.

Services Outside the Wellmark Service Area

BlueCard Program

This program ensures that members of any Blue Plan have access to the advantages of PPO Providers throughout the United States. Participating Providers have a contractual agreement with the Blue Cross and/or Blue Shield Plan in their home state ("Host Blue"). The Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a PPO Provider. Always carry your ID card (or BlueCard) and present it to your provider when you receive care. Information on it, especially the ID number, is required to process your claims correctly.

PPO Providers may not be available in some states. In this case, when you receive covered services from a non-PPO provider (i.e., a Participating or Out-of-Network provider), you will receive many of the same advantages as when you receive covered services from a PPO Provider. However, because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service. An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 5. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network

Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no Participating Provider who can furnish such item or service at such facility.

PPO Providers contract with the Blue Cross and/or Blue Shield preferred provider organization (PPO) in their home state.

When you receive covered services from PPO or Participating providers outside the Wellmark service area, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The group health plan payment is sent directly to the providers.
- Wellmark requires claims to be filed within 365 days following the date of service (or 180 days from date of discharge for inpatient claims). However, if the PPO or Participating provider's contract with the Host Blue has a requirement that a claim be filed in a timeframe exceeding 365 days following the date of service or date of discharge for inpatient claims, Wellmark will process the claim according to the Host Blue's contractual filing requirement. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

Typically, when you receive covered services from PPO or Participating providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 55. However, if you are admitted to a BlueCard facility outside the Wellmark service area, any PPO or Participating provider should handle notification requirements for you.

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the Wellmark service area, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described in the following paragraphs.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("Out-of-Network Providers") don't contract with the Host Blue. In the following paragraphs we explain how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described previously, except for all dental care benefits (except when paid as medical benefits), and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by us to provide the specific service or services.

BlueCard® Program
Under the BlueCard® Program, when you receive covered services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

When you receive covered services outside Wellmark's service area and the claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted previously. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed on to you.

Out-of-Network Providers Outside the Wellmark Service Area
Your Liability Calculation. When covered services are provided outside of our service area by Out-of-Network Providers, the amount you pay for such services will normally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered services as set forth in this summary plan description.

An exception to this is when the No Surprises Act applies to your items or services. In that case, the amount you pay will be determined in accordance with the Act. See *Payment Details*, page 5. Additionally, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no Participating Provider who can furnish such item or service at such facility.

In certain situations, we may use other payment methods, such as billed charges for covered services, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment to determine the amount we will pay for services provided by Out-of-Network Providers. In these situations, you may be liable for the difference between the amount that the Out-of-Network Provider bills and the payment we will make for the covered services as set forth in this summary plan description.

Care in a Foreign Country
For covered services you receive in a country other than the United States, payment level assumes the provider category is Out-of-Network except for services received from providers that participate with Blue Cross Blue Shield Global Core.

Blue Cross Blue Shield Global® Core Program
If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core Program when accessing covered services. The Blue Cross Blue Shield Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-BLUE** (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services. In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the Blue Cross Blue Shield Global Core Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered services. **You must contact us to obtain precertification for non-emergency inpatient services.**

Outpatient Services. Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered services. See *Claims*, page 95.

Submitting a Blue Cross Blue Shield Global Core Claim
When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from us, the Blue Cross Blue Shield Global Core Service Center, or online at *www.bcbsglobalcore.com*. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at **800-810-**

BLUE (2583) or call collect at **804-673-1177**, 24 hours a day, seven days a week.

Whenever possible, before receiving services outside the Wellmark service area, you should ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate PPO Providers in any state, call **800-810-BLUE**, or visit *www.bcbs.com*.

Iowa and South Dakota comprise the Wellmark service area.

Laboratory services. You may have laboratory specimens or samples collected by a PPO Provider and those laboratory specimens may be sent to another laboratory services provider for processing or testing. If that laboratory services provider does not have a contractual relationship with the Blue Plan where the specimen was drawn,* that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

*Where the specimen is drawn will be determined by which state the referring provider is located.

Home/durable medical equipment. If you purchase or rent home/durable medical equipment from a provider that does not have a contractual relationship with the Blue Plan where you purchased or rented the equipment, that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the home/durable medical equipment provider, that provider will be considered Out-of-Network and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase or rent home/durable medical equipment and have the equipment shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

Orthotics and prosthetic devices. If you purchase orthotics or prosthetic devices from a provider that does not have a contractual relationship with the Blue Plan where you purchased the orthotics or prosthetic devices, that provider will be considered an Out-of-Network Provider and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service.

If you purchase orthotics or prosthetic devices and have that equipment shipped to a service area of a Blue Plan that does not have a contractual relationship with the provider, that provider will be considered Out-of-Network and you will be responsible for any applicable Out-of-Network Provider payment obligations and you may also be responsible for any difference between the amount charged and our amount paid for the covered service. This includes situations where you purchase orthotics or prosthetic devices and have them shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the provider.

Talk to your provider. Whenever possible, before receiving laboratory services, home/durable medical equipment, orthotics, or prosthetic devices, ask your provider to utilize a provider that has a contractual arrangement with the Blue Plan

where you received services, purchased or rented equipment, or shipped equipment, or ask your provider to utilize a provider that has a contractual arrangement with Wellmark.

To determine if a provider has a contractual arrangement with a particular Blue Plan or with Wellmark, call the Customer Service number on your ID card or visit our website, *Wellmark.com*.

See *Out-of-Network Providers,* page 65.

Continuity of Care

If you are a Continuing Care Patient

- undergoing a course of treatment for a serious or complex condition,
- undergoing a course of institutional or inpatient care,
- scheduled to undergo nonelective surgery, including postoperative care with respect to such surgery,
- pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery, or
- receiving treatment for a terminal illness and, with respect to the provider or facility providing such treatment;
  - the network agreement between the provider or facility and Wellmark is terminated; or
  - benefits provided under this plan with respect to such provider or facility are terminated because of a change in the terms of the participation of such provider or facility in such plan or coverage;

then you may elect to continue to have benefits provided under this plan under the same terms and conditions as would have applied and with respect to such items and services as would have been covered under the plan as if the termination resulting in out-of-network status had not occurred. This Continuity of Care applies only with respect to the course of treatment furnished by such provider or facility relating to the condition affecting individual's status as a Continuing Care Patient. Claims for treatment of the condition from the provider or facility will be considered in-network claims until the earlier of (i) the date you are no longer considered a Continuing Care Patient, or (ii) the end of a 90 day period beginning on the date you have been notified of your opportunity to elect transitional care.

In order to elect transitional care as a Continuing Care Patient, you may respond to the letter Wellmark sends you, or you or your provider may call us at **800-552-3993**.

Prescription Drugs

Choosing a Pharmacy

Your prescription drug benefits are called Blue Rx Value Plus. Pharmacies that participate with the network used by Blue Rx Value Plus are called participating pharmacies. Pharmacies that do not participate with the network are called nonparticipating pharmacies.

You must purchase prescription drugs and pharmacy durable medical equipment devices from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Pharmacy Program* later in this section). If you purchase drugs or pharmacy durable medical equipment devices from nonparticipating pharmacies, you are responsible for the entire cost of the drug or pharmacy durable medical equipment device.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Always Present Your ID Card
If you do not have your ID card with you when you fill a prescription at a participating pharmacy, the pharmacist may not be able to access your benefit information. In this case:

- You must pay the full amount charged at the time you receive your prescription, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- You must file your claim to be reimbursed. See *Claims*, page 95.

Specialty Pharmacy Program

Specialty pharmacies deliver specialty drugs directly to your home or to your physician's office. You must purchase specialty drugs through the specialty pharmacy program. The specialty pharmacy program is limited to CVS Specialty®. You must register as a specialty pharmacy program user in order to fill your prescriptions through the specialty pharmacy program. For information on how to register, call the Customer Service number on your ID card or visit our website at *Wellmark.com*.

You are not covered for specialty drugs purchased outside the specialty pharmacy program unless the specialty drug is covered under your medical benefits.

The specialty pharmacy program administers the distribution of specialty drugs to the home and to physicians' offices.

Mail Order Drug Program

You must purchase mail order drugs through the mail order drug program. You are not covered for mail order drugs purchased outside the mail order drug program.

You must register as a mail service user in order to fill your prescriptions through the mail order drug program. For information on how to register, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Mail order pharmacy providers outside our mail order program are considered nonparticipating pharmacies. You are not covered for drugs purchased from nonparticipating mail order pharmacies.

See *Participating vs. Nonparticipating Pharmacies*, page 70.

F. Notification Requirements and Care Coordination

Medical

Many services including, but not limited to, medical, surgical, mental health, and chemical dependency treatment services, require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical. For a complete list of services subject to notification or review, visit *Wellmark.com* or call the Customer Service number on your ID card.

Providers and Notification Requirements
PPO or Participating providers in Iowa and South Dakota should handle notification requirements for you. If you are admitted to a PPO or Participating facility outside Iowa or South Dakota, the PPO or Participating provider should handle notification requirements for you.

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a PPO or Participating provider outside Iowa or South Dakota, or if you see an Out-of-Network Provider, you or someone acting on your behalf is responsible for notification requirements.

More than one of the notification requirements and care coordination programs described in this section may apply to a service. Any notification or care coordination decision is based on the medical benefits in effect at the time of your request. If your coverage changes for any reason, you may be required to repeat the notification process.

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 105. Also see *Authorized Representative*, page 115.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. Precertification is required; however, it does not apply to maternity or emergency services.
Applies to	For a complete list of the services subject to precertification, visit *Wellmark.com* or call the Customer Service number on your ID card.

Person Responsible for Obtaining Precertification	**You** or someone acting on your behalf is responsible for obtaining precertification if: ■ You receive services subject to precertification from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota; **Your Provider** should obtain precertification for you if: ■ You receive services subject to precertification from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to precertification from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether precertification has been obtained, call the Customer Service number on your ID card.
Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.

Importance	If you choose to receive services subject to precertification, you will be responsible for the charges as follows: ■ If you receive services subject to precertification from an Out-of-Network Provider and we determine that the procedure was not medically necessary you will be responsible for the full charge. ■ If you are admitted to a PPO or Participating inpatient facility, the provider, not you, will be responsible for any reduction for failure to complete the precertification process. **Please note:** It is important that you are aware of precertification requirements to help ensure that they are met. ■ If you receive the services from an Out-of-Network Provider and we determine the procedure is medically necessary and otherwise covered, without precertification, benefits can be reduced by 100% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed $200 per admission. This reduction maximum does not apply to home health services. See *Maximum Allowable Fee*, page 66. You are subject to this benefit reduction only if you receive the services from an Out-of-Network Provider. Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *What You Pay*, page 3.

Notification

Purpose	Notification of most facility admissions and certain services helps us identify and initiate discharge planning or care coordination. Notification is required.
Applies to	For a complete list of the services subject to notification, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	PPO Providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf is responsible for notification if: ■ You receive services subject to notification from a provider outside Iowa or South Dakota; ■ You receive services subject to notification from a Participating or Out-of-Network provider.
Process	When you, instead of your provider, are responsible for notification, call the phone number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify us within one business day of the admission or the receipt of services or as soon as reasonably possible thereafter.

Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.
Applies to	For a complete list of the services subject to prior approval, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible for Obtaining Prior Approval	**You** or someone acting on your behalf is responsible for obtaining prior approval if: ■ You receive services subject to prior approval from an Out-of-Network Provider; or ■ You receive non-inpatient services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Your Provider** should obtain prior approval for you if: ■ You receive services subject to prior approval from a PPO Provider in Iowa or South Dakota; or ■ You receive inpatient services subject to prior approval from a PPO or Participating provider outside Iowa or South Dakota. **Please note:** If you are ever in doubt whether prior approval has been obtained, call the Customer Service number on your ID card.
Process	When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form. Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request in writing to you and your provider within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.

Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and benefits maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Appeals* section) and provide us with medical information for our consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if we determine the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits. Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended. **Note:** When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See *Precertification* and *Notification* earlier in this section.

Concurrent Review

Purpose	Concurrent review is a utilization review conducted during a member's facility stay or course of treatment at home or in a facility setting to determine whether the place or level of service is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	For a complete list of the services subject to concurrent review, visit *Wellmark.com* or call the Customer Service number on your ID card.
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary. Responses to Wellmark's concurrent review requests must include supporting clinical information to determine medical necessity as a condition of your coverage.
Importance	Wellmark may require a change in the level or place of service in order to continue providing benefits. If we determine that your current facility setting or level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.

Care Management

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

Prescription Drugs

Prior Authorization of Drugs

Purpose	Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary.
Applies to	Consult the Drug List to determine if a particular drug requires prior authorization. You can locate this list by visiting *Wellmark.com*. You may also check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.
Person Responsible	You are responsible for prior authorization.

Process	Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription. Wellmark will respond to a prior authorization request within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Calls received after 4:00 p.m. are considered the next business day.
Importance	If you purchase a drug that requires prior authorization but do not obtain prior authorization, you are responsible for paying the entire amount charged.

G. Factors Affecting What You Pay

How much you pay for covered services is affected by many different factors discussed in this section.

Medical

Benefit Year

A benefit year is a period of 12 consecutive months beginning on January 1 or beginning on the day your coverage goes into effect. The benefit year starts over each January 1. Your benefit year continues even if your employer or group sponsor changes Wellmark group health plan benefits during the year or you change to a different plan offering mid-benefit year from your same employer or group sponsor.

Certain coverage changes result in your Wellmark identification number changing. In some cases, a new benefit year will start under the new ID number for the rest of the benefit year. In this case, the benefit year would be less than a full 12 months. In other cases (e.g., adding your spouse to your coverage) the benefit year would continue and not start over.

If you are an inpatient in a covered facility on the date of your annual benefit year renewal, your benefit limitations and payment obligations, including your deductible and out-of-pocket maximum, for facility services will renew and will be based on the benefit limitations and payment obligation amounts in effect on the date you were admitted. However, your payment obligations, including your deductible and out-of-pocket maximum, for practitioner services will be based on the payment obligation amounts in effect on the day you receive services.

The benefit year is important for calculating:

- Deductible.
- Coinsurance.
- Out-of-pocket maximum.
- Benefits maximum.

How Coinsurance is Calculated

The amount on which coinsurance is calculated depends on the state where you receive a covered service and the contracting status of the provider.

PPO Providers in the Wellmark Service Area and Out-of-Network Providers

Coinsurance is calculated using the payment arrangement amount after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 5.

PPO and Participating Providers Outside the Wellmark Service Area

The coinsurance for covered services is calculated on the lower of:

- The amount charged for the covered service, or
- The negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Certain copayments.
  - Amounts representing any general exclusions and conditions. See

General Conditions of Coverage, Exclusions, and Limitations, page 41.

Often, the negotiated price will be a simple discount that reflects an actual price the local Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Occasionally, claims for services you receive from a provider that participates with a Blue Cross and/or Blue Shield Plan outside of Iowa or South Dakota may need to be processed by Wellmark instead of by the BlueCard Program. In that case, coinsurance is calculated using the payment arrangement amount for covered services after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 41.

Laws in a small number of states may require the Host Blue Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, Wellmark will calculate your payment obligation for any covered services according to applicable law. For more information, see *BlueCard Program*, page 48.

The No Surprises Act may impact deductible, coinsurance, and out-of-pocket maximum calculations. See *Payment Details*, page 5.

Provider Network

Under the medical benefits of this plan, your network of providers consists of PPO and Participating providers. All other providers are Out-of-Network Providers.

PPO Providers

Blue Cross and Blue Shield Plans have contracting relationships with PPO Providers. When you receive services from PPO Providers:

- The PPO payment obligation amounts may be waived or may be less than the Participating and Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 8.
- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with Participating Providers. Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers. To determine if a pharmacy contracts with our pharmacy benefits manager, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. When you receive services from Participating Providers:

- The Participating payment obligation amounts may be waived or may be less than the Out-of-Network amounts for certain covered services. See *Waived Payment Obligations*, page 8.
- These providers agree to accept Wellmark's payment arrangements, or payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

Out-of-Network Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with Out-of-Network Providers, and they may not accept our payment arrangements. Pharmacies other than those participating in the specialty pharmacy program that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers. Therefore, when you receive services from Out-of-Network Providers:

- The following is true unless the No Surprises Act applies:

  You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by an Out-of-Network Provider will generally be based on either the Host Blue's Out-of-Network Provider local payment or the pricing arrangements required by applicable state law. In certain situations, we may use other payment bases, such as the amount charged for a covered service, the payment we would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to determine the amount we will pay for services you receive from Out-of-Network Providers. See *Services Outside the Wellmark Service Area,* page 48. However, when you receive services in an in-network facility and are provided covered services by an Out-of-Network ancillary provider, in-network cost-share will be applied and accumulate toward the out-of-pocket maximum. For this purpose, ancillary providers include pathologists, emergency room physicians, anesthesiologists, radiologists, or hospitalists. Because we do not have contracts with Out-of-Network Providers and they may not accept our payment arrangements, you will still be responsible for any difference between the billed charge and our settlement amount for the services from the Out-of-Network ancillary provider unless the No Surprises Act applies.
- Wellmark does not make claim payments directly to these providers, and you are responsible for ensuring that your provider is paid in full, unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- The group health plan payment for Out-of-Network hospitals, M.D.s, and D.O.s in Iowa is made payable to the provider, but the check is sent to you, and you are responsible for forwarding the check to the provider (plus any billed balance you may owe), unless the No Surprises Act applies, in which case Wellmark will pay the Out-of-Network Provider directly.
- When the No Surprises Act applies to your items or services, you cannot be billed for the difference between the amount charged and the total amount paid by us. The only exception to this would be if an eligible Out-of-Network Provider performing services in a participating facility gives you proper notice in plain language that you will be receiving services from an Out-of-Network Provider and you consent to be balance-billed and to have the amount that you pay determined without

reference to the No Surprises Act. Certain providers are not permitted to provide notice and request consent for this purpose. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or nonphysician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by a nonparticipating provider, only if there is no Participating Provider who can furnish such item or service at such facility.

Amount Charged and Maximum Allowable Fee

Amount Charged

The amount charged is the amount a provider charges for a service or supply, regardless of whether the services or supplies are covered under your medical benefits.

Maximum Allowable Fee

The maximum allowable fee is the amount, established by Wellmark, using various methodologies, for covered services and supplies. Wellmark's amount paid may be based on the lesser of the amount charged for a covered service or supply or the maximum allowable fee.

Payment Arrangements

Payment Arrangement Savings

Wellmark has contracting relationships with PPO Providers. We use different methods to determine payment arrangements, including negotiated fees. These payment arrangements usually result in savings.

The savings from payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a Participating or PPO provider. For the majority of services, the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a provider could be different from the covered charge. Regardless of the amount we pay a Participating or PPO provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you may be responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, benefit year maximum, or lifetime benefits maximum; reductions or denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from an Out-of-Network Provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 41.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
  - Deductible.
  - Coinsurance.
  - Copayment.
  - Amounts representing any general exclusions and conditions.
  - Network savings.

Payment Method for Services

When you receive a covered service or services that result in multiple claims, we will calculate your payment obligations based on the order in which we process the claims.

Provider Payment Arrangements
Provider payment arrangements are calculated using industry methods including, but not limited to, fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. PPO and Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Pharmacy Benefits Manager Fees and Drug Company Rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services to its accounts, such as your group. Your group is to pay a monthly fee for such services.

Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark prescription drug coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group's use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to us by the pharmacy benefits manager unless your group's arrangement with us requires us to reduce such rebated amounts by the amount of any fees we paid to the pharmacy benefits manager for the services rendered to your group. We will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.

Prescription Drugs

Benefit Year

A benefit year is a period of 12 consecutive months beginning on January 1 or beginning on the day your coverage goes into effect. The benefit year starts over each January 1. Your benefit year continues even if your employer or group sponsor changes Wellmark group health plan benefits during the year or you change to a different plan offering mid-benefit year from your same employer or group sponsor.

Certain coverage changes result in your Wellmark identification number changing. In some cases, a new benefit year will start under the new ID number for the rest of the benefit year. In this case, the benefit year would be less than a full 12 months. In other cases (e.g., adding your spouse to your coverage) the benefit year would continue and not start over.

The benefit year is important for calculating:

- Out-of-pocket maximum.

Wellmark Blue Rx Value Plus Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Blue Rx Value Plus Drug List ("Drug List") contains drugs and pharmacy durable medical equipment devices physicians recognize as medically effective for a wide range of health conditions.

The Drug List is maintained with the assistance of practicing physicians,

pharmacists, and Wellmark's pharmacy department.

To determine if a drug or pharmacy durable medical equipment device is covered, you or your physician must consult the Drug List. If a drug or pharmacy durable medical equipment device is not on the Drug List, it is not covered.

If you need help determining if a particular drug or pharmacy durable medical equipment device is on the Drug List, ask your physician or pharmacist, visit our website, *Wellmark.com*, or call the Customer Service number on your ID card.

Although only drugs and pharmacy durable medical equipment devices listed on the Drug List are covered, physicians are not limited to prescribing only the drugs on the list. Physicians may prescribe any medication, but only medications on the Drug List are covered. **Please note:** A medication or pharmacy durable medical equipment device on the Drug List will not be covered if the drug or pharmacy durable medical equipment device is specifically excluded under your Blue Rx Value Plus prescription drug benefits, or other limitations apply.

If a drug or pharmacy durable medical equipment device is not on the Wellmark Blue Rx Value Plus Drug List and you believe it should be covered, refer to *Exception Requests for Non-Formulary Prescription Drugs,* page 97.

The Wellmark Blue Rx Value Plus Drug List is subject to change.

Tiers

The Wellmark Blue Rx Value Plus Drug List also identifies which tier a drug is on:

Tier 1. Most generic drugs and some brand-name drugs that have no medically appropriate generic equivalent. Tier 1 drugs have the lowest payment obligation.

Tier 2. Drugs appear on this tier because they either have no medically appropriate generic equivalent or are considered less cost-effective than Tier 1 drugs. Tier 2 drugs have a higher payment obligation than Tier 1 drugs.

Tier 3. Drugs appear on this tier because they are less cost-effective than Tier 1 or Tier 2 drugs. Tier 3 drugs have the highest payment obligation.

Pharmacy DME. Devices available on this tier include select durable medical equipment (DME) that are used in conjunction with a drug and may be obtained from a pharmacy.

Preferred vs. Non-Preferred Specialty Drugs

The Wellmark Blue Rx Value Plus Drug List also identifies which tier a specialty drug is on:

Preferred Specialty Drugs have been proven to be safe, effective, and favorably priced compared to non-preferred alternatives that treat the same condition. Drugs may also be classified as preferred because no alternative drug exists.

Non-Preferred Specialty Drugs are drugs without sufficiently documented clinical evidence establishing that they provide a significant benefit over available preferred alternatives.

The amount you pay for specialty drugs covered under your Blue Rx Value Plus prescription drug benefits depends on whether a specialty drug is categorized as preferred or non-preferred. To determine whether a specialty drug is preferred or non-preferred, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*. Also see *Specialty Drugs*, page 31.

Generic and Brand Name Drugs

Generic Drug

Generic drug refers to an FDA-approved "A"-rated generic drug. This is a drug with active therapeutic ingredients chemically identical to its brand name drug counterpart.

Brand Name Drug
Brand name drug is a prescription drug patented by the original manufacturer. Usually, after the patent expires, other manufacturers may make FDA-approved generic copies.

Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, Wellmark's pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

What You Pay
In most cases, when you purchase a brand name drug that has an FDA-approved "A"-rated medically appropriate generic equivalent, Wellmark will pay only what it would have paid for the medically appropriate equivalent generic drug. You will be responsible for your payment obligation for the medically appropriate equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.

However, if your physician writes "dispense as written" on your prescription

- You will not be responsible for the cost difference between the generic drug and the brand name drug;
- You will be responsible for your payment obligation for the brand name drug.

Biologics and Biosimilars

Biologics are specialty drugs made from natural and living sources and are usually more complex than other drugs. They are often more complicated to purify, process, and manufacture.

Biosimilar Drug
A biosimilar is a biologic drug. It is highly similar to a biologic drug already approved by the FDA – the original biologic (also called the reference product). Biosimilars also have no clinically meaningful differences from the reference product. This means you can expect the same safety and effectiveness from the biosimilar over the course of treatment as you would the reference product. Biosimilars are made from the same types of natural and living sources and are just as safe and effective as their reference products.

Interchangeable Biosimilar Drug
Interchangeable biosimilar drug refers to an FDA-approved biosimilar drug that meets additional requirements based on further evaluation and testing. This drug is expected to produce the same clinical result as the reference product.

Reference Biologic Drug
A reference product is the single brand biologic drug, already approved by the FDA, against which a proposed biosimilar drug is compared to and evaluated against to ensure that the product is highly similar and has no clinically meaningful differences.

What You Pay
To determine what you would pay for a biologic or biosimilar specialty drug, consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*. In most cases, when you purchase a reference biologic drug that has an FDA-approved interchangeable biosimilar, Wellmark will pay only what it would have paid for the medically appropriate equivalent interchangeable biosimilar drug. You will be responsible for your payment obligation for the medically appropriate equivalent interchangeable biosimilar drug and any remaining cost difference up to the maximum allowed fee for the brand name reference biologic drug.

However, if your physician writes "dispense as written" on your prescription:

- You will not be responsible for the cost difference between the interchangeable biosimilar drug and the reference biologic drug;

- You will be responsible for your payment obligation for the reference biologic drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription.

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount prescribed by your physician.

In addition, coverage for certain drugs or pharmacy durable medical equipment devices is limited to specific quantities per month, benefit year, or lifetime. Amounts in excess of quantity limitations are not covered.

For a list of drugs and pharmacy durable medical equipment devices with quantity limits, check with your pharmacist or physician or consult the Wellmark Blue Rx Value Plus Drug List at *Wellmark.com*, or call the Customer Service number on your ID card.

Amount Charged and Maximum Allowable Fee

Amount Charged

The retail price charged by a pharmacy for a covered prescription drug or pharmacy durable medical equipment device.

Maximum Allowable Fee

The amount, established by Wellmark using various methodologies and data (such as the average wholesale price), payable for covered drugs and pharmacy durable medical equipment devices.

The maximum allowable fee may be less than the amount charged for the drug or pharmacy durable medical equipment device.

Participating vs. Nonparticipating Pharmacies

You must purchase prescription drugs and pharmacy durable medical equipment devices from participating pharmacies (excluding specialty drugs, which must be purchased through the specialty pharmacy program. See *Specialty Drugs*, page 31). Purchases from nonparticipating pharmacies are not covered. If you purchase drugs or pharmacy durable medical equipment devices from nonparticipating pharmacies, you are responsible for the cost of the drug or pharmacy durable medical equipment device.

Your payment obligation for the purchase of a covered prescription drug at a participating pharmacy is the lesser of your coinsurance, the maximum allowable fee, or the amount charged for the drug.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies on our website at *Wellmark.com*, or call the Customer Service number on your ID card. Our directory also is available upon request by calling the Customer Service number on your ID card.

Special Programs

We evaluate and monitor changes in the pharmaceutical industry in order to determine clinically effective and cost-effective coverage options. These evaluations may prompt us to offer programs that encourage the use of reasonable alternatives. For example, we may, at our discretion, temporarily waive your payment obligation on a qualifying prescription drug purchase.

Visit our website at *Wellmark.com* or call us to determine whether your prescription qualifies.

Savings and Rebates

Payment Arrangements

The benefits manager of this prescription drug program has established payment

arrangements with participating pharmacies that may result in savings.

Pharmacy Benefits Manager Fees and Drug Company Rebates

Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services to its accounts, such as your group. Your group is to pay a monthly fee for such services.

Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark prescription drug coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group's use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to us by the pharmacy benefits manager unless your group's arrangement with us requires us to reduce such rebated amounts by the amount of any fees we paid to the pharmacy benefits manager for the services rendered to your group. We will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.

H. Claims

Once you receive services, we must receive a claim to determine the amount of your benefits. The claim lets us know the services you received, when you received them, and from which provider.

Neither you nor your provider shall bill Wellmark for services provided under a direct primary care agreement as authorized under Iowa law.

When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. Participating and PPO providers file claims for you.
- Purchase prescription drugs from a participating pharmacy but do not present your ID card.
- Pay in full for a drug that you believe should have been covered.

Your submission of a prescription to a participating pharmacy is not a filed claim and therefore is not subject to appeal procedures as described in the *Appeals* section. However, you may file a claim with us for a prescription drug purchase you think should have been a covered benefit.

Wellmark must receive claims within 365 days following the date of service of the claim or if you have other coverage that has primary responsibility for payment then within 365 days of the date of the other carrier's explanation of benefits. If you receive services outside of Wellmark's service area, Wellmark must receive the claim within 365 days following the date of service (or 180 days from date of discharge for inpatient claims) or within the filing requirement in the contractual agreement between the Participating Provider and the Host Blue. If you receive services from an Out-of-Network Provider, the claim has to be filed within 365 days following the date of service or date of discharge for inpatient claims.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form
Forms are available at *Wellmark.com* or by calling the Customer Service number on your ID card or from your personnel department.

2. Fill Out the Claim Form
Follow the same claim filing procedure regardless of where you received services. Directions are printed on the back of the claim form. Complete all sections of the claim form. For more efficient processing, all claims (including those completed out-of-country) should be written in English.

If you need assistance completing the claim form, call the Customer Service number on your ID card.

Medical Claim Form. Follow these steps to complete a medical claim form:

- Use a separate claim form for each covered family member and each provider.
- Attach a copy of an itemized statement prepared by your provider. We cannot accept statements you prepare, cash register receipts, receipt of payment notices, or balance due notices. In order for a claim request to qualify for processing, the itemized statement must be on the provider's stationery, and include at least the following:
  - Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
  - Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.
  - Date(s) of service.

- Charge for each service.
- Place of service (office, hospital, etc.).
- For injury or illness: date and diagnosis.
- For inpatient claims: admission date, patient status, attending physician ID.
- Days or units of service.
- Revenue, diagnosis, and procedure codes.
- Description of each service.

Prescription Drugs Covered Under Your Medical Benefits Claim Form. For prescription drugs covered under your medical benefits (not covered under your Blue Rx Value Plus prescription drug benefits), use a separate prescription drug claim form and include the following information:

- Pharmacy name and address.
- Patient information: first and last name, date of birth, gender, and relationship to plan member.
- Date(s) of service.
- Description and quantity of drug.
- Original pharmacy receipt or cash receipt with the pharmacist's signature on it.

Blue Rx Value Plus Prescription Drug Claim Form. For prescription drugs covered under your Blue Rx Value Plus prescription drug benefits, complete the following steps:

- Use a separate claim form for each covered family member and each pharmacy.
- Complete all sections of the claim form. Include your daytime telephone number.
- Submit up to three prescriptions for the same family member and the same pharmacy on a single claim form. Use additional claim forms for claims that exceed three prescriptions or if the prescriptions are for more than one family member or pharmacy.
- Attach receipts to the back of the claim form in the space provided.

3. Sign the Claim Form

4. Submit the Claim
We recommend you retain a copy for your records. The original form you send or any attachments sent with the form cannot be returned to you.

Medical Claims and Claims for Drugs Covered Under Your Medical Benefits. Send the claim to:

Wellmark
Station 1E238
P.O. Box 9291
Des Moines, IA 50306-9291

Medical Claims for Services Received Outside the United States. Send the claim to the address printed on the claim form.

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

We may require additional information from you or your provider before a claim can be considered complete and ready for processing.

Notification of Decision

You will receive an Explanation of Benefits (EOB) following your claim. The EOB is a statement outlining how we applied benefits to a submitted claim. It details amounts that providers charged, network savings, our paid amounts, and amounts for which you are responsible.

In case of an adverse decision, the notice will be sent within 30 days of receipt of the claim. We may extend this time by up to 15 days if the claim determination is delayed for reasons beyond our control. If we do not send an explanation of benefits statement or a notice of extension within the 30-day period, you have the right to begin an appeal. We will notify you of the circumstances requiring an extension and

the date by which we expect to render a decision.

If an extension is necessary because we require additional information from you, the notice will describe the specific information needed. You have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied.

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 99.

Once we pay your claim, whether our payment is sent to you or to your provider, our obligation to pay benefits for the claim is discharged. However, we may adjust a claim due to overpayment or underpayment. In the case of Out-of-Network hospitals, M.D.s, and D.O.s located in Iowa, the health plan payment is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider, plus any difference between the amount charged and our payment.

Exception Requests for Non-Formulary Prescription Drugs

Prescription drugs that are not listed on the Wellmark Blue Rx Value Plus Drug List are not covered. However, you may submit an exception request for coverage of a non-formulary drug (i.e., a drug that is not included on the Wellmark Blue Rx Value Plus Drug List). The form is available at *Wellmark.com* or by calling the Customer Service number on your ID card. Your prescribing physician or other provider must provide a clinical justification supporting the need for the non-formulary drug to treat your condition. The provider should include a statement that:

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

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

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

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

Request for Benefit Exception Review

If you have received an adverse benefit determination that denies or reduces benefits or fails to provide payment in whole or in part for any of the following services, when recommended by your treating provider as medically necessary, you or an individual acting as your authorized representative may request a benefit exception review.

Services subject to this exception process:

- For a woman who previously has had breast cancer, ovarian cancer, or other cancer, but who has not been diagnosed with BRCA-related cancer, appropriate preventive screening, genetic counseling, and genetic testing.
- FDA-approved contraceptive items or services prescribed by your health care provider based upon a specific determination of medical necessity for you.
- For transgender individuals, sex-specific preventive care services (e.g., mammograms and Pap smears) that your attending provider has determined are medically appropriate.
- For dependent children, certain well-woman preventive care services that the attending provider determined are age- and developmentally-appropriate.
- Anesthesia services in connection with a preventive colonoscopy when your attending provider determined that anesthesia would be medically appropriate.
- A required consultation prior to a screening colonoscopy, if your attending provider determined that the pre-procedure consultation would be medically appropriate for you.
- If you received pathology services from an in-network provider related to a preventive colonoscopy screening for which you were responsible for a portion of the cost, such as a deductible, copayment or coinsurance.
- Certain immunizations that ACIP recommends for specified individuals (rather than for routine use for an entire population), when prescribed by your health care provider consistent with the ACIP recommendations.
- FDA-approved intrauterine devices and implants, if prescribed by your health care provider.
- Brand name drug when the generic equivalent drug is available, if your provider determines the brand name drug is medically necessary and the generic equivalent drug is medically inappropriate.

You may request a benefit exception review orally or in writing by submitting your request to the address listed in the *Appeals* section. To be considered, your request must include supporting medical record documentation and a letter or statement from your treating provider that the services or supplies were medically necessary and your treating provider's reason(s) for their determination that the services or supplies were medically necessary.

Your request will be addressed within the timeframes outlined in the *Appeals* section based upon whether your request is a medically urgent or non-medically urgent matter.

I. Coordination of Benefits

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

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

Other Coverage

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

- Group and nongroup insurance contracts and subscriber contracts.
- HMO contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term contracts, such as skilled nursing care.
- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

Coverage that is not subject to coordination of benefits includes the following:

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for nonmedical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

You must cooperate with Wellmark and provide requested information about other coverage. Failure to provide information can result in a denied claim. We may get the facts we need from or give them to other organizations or persons for the purpose of applying the following rules and determining the benefits payable under this plan and other plans covering you. We need not tell, or get the consent of, any person to do this.

Your Participating or PPO provider will forward your coverage information to us. If you see an Out-of-Network Provider, you are responsible for informing us about your other coverage.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment within 365 days of the date of the other carrier's explanation of benefits. We may contact your provider or the other carrier for further information.

Rules of Coordination

We follow certain rules to determine which health plan or coverage pays first (as the primary plan) when other coverage provides the same or similar benefits as this group health plan. Here are some of those rules:

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide Out-of-Network benefits.)

The following rules are to be applied in order. The first rule that applies to your situation is used to determine the primary plan.

- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Notwithstanding the preceding rules, when you present your Blue Rx Value Plus ID card to a pharmacy as the primary payer, your Blue Rx Value Plus prescription drug benefits are primary for prescription drugs purchased at the pharmacy. If, under the preceding rules, your Blue Rx Value Plus prescription drug benefits are secondary and you present your Blue Rx Value Plus ID card to a pharmacy as the secondary payer, your Blue Rx Value Plus prescription drug benefits are secondary for prescription drugs purchased at the pharmacy.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

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

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
  - If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.
- For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as outlined previously in this *Dependent Children* section.
- For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the plan that covered the dependent for the longer period of time is the primary plan. If the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined, as applicable, as outlined in the first bullet of this *Dependent Children* section, to the dependent child's parent or parents and the dependent's spouse.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Coordination with Noncomplying Plans

If you have coverage with another plan that is excess or always secondary or that does not comply with the preceding rules of coordination, we may coordinate benefits on the following basis:

- If this is the primary plan, we will pay its benefits first.
- If this is the secondary plan, we will pay benefits first, but the amount of benefits will be determined as if this plan were secondary. Our payment will be limited to the amount we would have paid had this plan been primary.
- If the noncomplying plan does not provide information needed to determine benefits, we will assume that the benefits of the noncomplying plan are identical to this plan and will administer benefits accordingly. If we receive the necessary information within two years of payment of the claim, we will adjust payments accordingly.
- In the event that the noncomplying plan reduces its benefits so you receive less than you would have received if we had paid as the secondary plan and the noncomplying plan was primary, we will advance an amount equal to the difference. In no event will we advance more than we would have paid had this plan been primary, minus any amount previously paid. In consideration of the advance, we will be subrogated to all of your rights against the noncomplying plan. See *Subrogation*, page 118.
- If the preceding rules do not determine the order of benefits and if the plans cannot agree on the order of benefits within 30 calendar days after the plans have received all information needed to pay the claim, the plans will pay the claim in equal shares and determine their relative liabilities following payment. However, we will not pay more than we would have paid had this plan been primary.

Effects on the Benefits of this Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

If a person is enrolled in two or more closed panel plans and if, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right of Recovery

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

Plans That Provide Benefits as Services

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the service from the primary plan, to the extent benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations. **Please note:** For a member covered by Medicare Part A, benefits under this medical benefits plan will be coordinated with benefits available under Medicare Part A and Part B, even if the member is not enrolled in Medicare Part B. When the member is not enrolled in Medicare Part B, and Medicare otherwise would be the primary payer under Medicare Secondary Payer regulations if the member were enrolled in Medicare Part B, Wellmark will calculate its payment responsibility by reducing its Maximum Allowable Fee calculation by 80%. The amount of the reduction in benefits attributable to the member's eligibility for Medicare Part B but failure to enroll in such coverage is not a covered benefit. Therefore, a member enrolled in Medicare Part A should also consider enrolling in Medicare Part B.

The following provisions apply only if you have both Medicare and employer group health coverage and meet the specific Medicare Secondary Payer provisions for the applicable Medicare entitlement reason.

Medicare Part B Drugs

Drugs paid under Medicare Part B are covered under the medical benefits of this plan.

Working Aged

If you are a member of a group health plan of an employer with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

If you are a member of a group health plan of an employer with at least 100 full-time, part-time, or leased employees on at least 50 percent of regular business days during the preceding calendar year, then in most situations Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these requirements, Medicare is the secondary payer during the first 30 months of Medicare eligibility if both of the following are true:

- The beneficiary is eligible for Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary becomes eligible for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws. For complete information, contact your employer or the Social Security Administration.

J. Appeals

Right of Appeal

You have the right to one full and fair review in the case of an adverse benefit determination, including a determination on a surprise bill, that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim, a rescission of coverage, or an adverse benefit determination concerning a pre-service notification requirement. Pre-service notification requirements are:

- A precertification request.
- A notification of admission or services.
- A prior approval request.
- A prior authorization request for prescription drugs.

How to Request an Internal Appeal

You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of our adverse benefit determination by submitting a written appeal. Appeal forms are available at our website, *Wellmark.com*. See *Authorized Representative*, page 115.

Medically Urgent Appeal

To appeal an adverse benefit determination involving a medically urgent situation, you may request an expedited appeal, either orally or in writing. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision.

Non-Medically Urgent Appeal

To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

What to Include in Your Internal Appeal

You must submit all relevant information with your appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

For a prescription drug appeal, you also must submit:

- Name and phone number of the pharmacy.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

If you have difficulty obtaining this information, ask your provider or pharmacist to assist you.

Where to Send Internal Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232

Review of Internal Appeal

Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or

not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you prior to Wellmark issuing a final adverse benefit determination and you will have the opportunity to respond to that information or to provide information.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, we will consult an appropriate medical expert who was not previously involved in the original decision and who has no conflict of interest in making the decision. If we deny your appeal, in whole or in part, you may request, in writing, the identity of the medical expert we consulted.

Decision on Internal Appeal

The decision on appeal is the final internal determination. Once a decision on internal appeal is reached, your right to internal appeal is exhausted.

Medically Urgent Appeal

For a medically urgent appeal, you will be notified (by telephone, e-mail, fax or another prompt method) of our decision as soon as possible, based on the medical situation, but no later than 72 hours after your expedited appeal request is received. If the decision is adverse, a written notification will be sent.

All Other Appeals

For all other appeals, you will be notified in writing of our decision. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days.

External Review

You have the right to request an external review of a final adverse determination involving a covered service when the determination involved:

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- A surprise bill.
- Concurrent review or admission to a facility. See *Notification Requirements and Care Coordination*, page 55.
- A rescission of coverage.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under this plan.

The external review will be conducted by independent health care professionals who have no association with us and who have no conflict of interest with respect to the benefit determination.

Have you exhausted the appeal process? Before you can request an external review, you must first exhaust the internal appeal process described earlier in this section. However, if you have not received a decision regarding the adverse benefit determination within 30 days following the date of your request for an appeal, you are considered to have exhausted the internal appeal process.

Requesting an external review. You or your authorized representative may request an external review through the Iowa Insurance Division by completing an External Review Request Form and submitting the form as described in this section. You may obtain this request form by calling the Customer Service number on your ID card, by visiting our website at *Wellmark.com*, by contacting the Iowa Insurance Division, or by visiting the Iowa

Insurance Division's website at *www.iid.iowa.gov*.

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on your request for external review.

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

Iowa Insurance Division
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
Fax: 515-654-6500
E-mail:
iid.marketregulation@iid.iowa.gov

How the review works. Upon notification that an external review request has been filed, Wellmark will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, the Iowa Insurance Division will decide whether your request is eligible for an external review, and if it is, the Iowa Insurance Division will assign an independent review organization (IRO) to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date the Iowa Insurance Division receives your request for an external review.

Need help? You may contact the Iowa Insurance Division at **877-955-1212** at any time for assistance with the external review process.

Expedited External Review
You do not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if you have a medical condition for which the time frame for completing an internal appeal or for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

You may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, concurrent review, or service for which you received emergency services, and you have not been discharged from a facility.

If our adverse benefit determination is that the service or treatment is investigational or experimental and your treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, you may also have the right to request an expedited external review.

You or your authorized representative may submit an oral or written expedited external review request to the Iowa Insurance Division by contacting the Iowa Insurance Division at **877-955-1212**.

If the Insurance Division determines the request is eligible for an expedited external review, the Division will immediately assign an IRO to conduct the review and a decision will be made expeditiously, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

Arbitration and Legal Action

You shall not start arbitration or legal action against us until you have exhausted the appeal procedure described in this section. See the *Arbitration and Legal Action* section and *Governing Law*, page 117, for important information about your arbitration and legal action rights after you have exhausted the appeal procedures in this section.

K. General Provisions

Contract

The conditions of your coverage are defined in your contract. Your contract includes:

- Any application you submitted to us or to your employer or group sponsor.
- Any agreement or group policy we have with your employer or group sponsor.
- Any application completed by your employer or group sponsor.
- This summary plan description and any amendments.

All of the statements made by you or your employer or group sponsor in any of these materials will be treated by us as representations, not warranties.

Interpreting this Summary Plan Description

We will interpret the provisions of this summary plan description and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this summary plan description. If any benefit described in this summary plan description is subject to a determination of medical necessity, we will make that factual determination. Our interpretations and determinations are final and conclusive, subject to the appeal procedures outlined earlier in this summary plan description.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your summary plan description. You should become familiar with the entire document.

Plan Year

The Plan Year has been designated and communicated to Wellmark by your group health plan's plan sponsor or plan administrator as the twelve month period commencing on the effective date of your group health plan's annual renewal with Wellmark.

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this summary plan description at any time. Any amendment or modification will be in writing and will be as binding as this summary plan description. If your contract is terminated, you may not receive benefits.

Authorized Group Benefits Plan Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions described in this summary plan description. This summary plan description cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 83.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at *Wellmark.com* or by calling the Customer Service number on your ID card.

In a medically urgent situation your treating health care practitioner may act as your

authorized representative without completion of the Authorized Representative Form.

An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You may authorize only one person as your representative at a time. You may revoke the authorized representative at any time.

Release of Information

By enrolling in this group health plan, you have agreed to release any necessary information requested about you so we can process claims for benefits.

You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts when providing information, then we may terminate your coverage under this group health plan.

Privacy of Information

Your employer or group sponsor is required to protect the privacy of your health information. It is required to request, use, or disclose your health information only as permitted or required by law. For example, your employer or group sponsor has contracted with Wellmark to administer this group health plan and Wellmark will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

Treatment

We may disclose your health information to a physician or other health care provider in order for such health care provider to provide treatment to you.

Payment

We may use and disclose your health information to pay for covered services from physicians, hospitals, and other providers, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from your employer or group sponsor, to issue explanations of benefits to the person enrolled in the group health plan in which you participate, and the like. We may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

Health Care Operations

We may use and disclose your health information in connection with health care operations. Health care operations include, but are not limited to, determining payment and rates for your group health plan; quality assessment and improvement activities; reviewing the competence or qualifications of health care practitioners, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities; medical review, legal services, and auditing, including fraud and abuse detection and compliance; business planning and development; and business management and general administrative activities.

Other Disclosures

Your employer or group sponsor or Wellmark is required to obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Member Health Support Services

Wellmark may from time to time make available to you certain health support services (such as disease management), for a fee or for no fee. Wellmark may offer financial and other incentives to you to use such services. As a part of the provision of these services, Wellmark may:

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health support service vendors, for purposes of providing such services to you.

Wellmark will use and disclose information according to the terms of our Privacy Practices Notice, which is available upon request or at *Wellmark.com*.

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include Blue365®, identity theft protections, and discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions. Wellmark may also provide rewards or incentives under this plan if you participate in certain voluntary wellness activities or programs that encourage healthy behaviors. Your employer is responsible for any income and employment tax withholding, depositing and reporting obligations that may apply to the value of such rewards and incentives.

Value-Based Programs

Value-based programs involve local health care organizations that are held accountable for the quality and cost of care delivered to a defined population. Value-based programs can include accountable care organizations (ACOs), patient centered medical homes (PCMHs), and other programs developed by Wellmark, the Blue Cross Blue Shield Association, or other Blue Cross Blue Shield health plans ("Blue Plans"). Wellmark and Blue Plans have entered into collaborative arrangements with value-based programs under which the health care providers participating in them are eligible for financial incentives relating to quality and cost-effective care of Wellmark and/or Blue Plan members. If your physician, hospital, or other health care provider participates in the Wellmark ACO program or other value-based program, Wellmark may make available to such health care providers your health care information, including claims information, for purposes of helping support their delivery of health care services to you.

Nonassignment

Except as required by law, benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Whether made before or after services are provided, you are prohibited from assigning any claim. You are further prohibited from assigning any cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan, even if assignment includes the provider's rights to receive payment, will be null and void. Nothing contained in this group health plan shall be construed to make the health plan or Wellmark liable to any third party to whom a member may be liable for medical care, treatment, or services.

Governing Law

To the extent not superseded by the laws of the United States, the group health plan will be construed in accordance with and governed by the laws of the state of Iowa.

Medicaid Enrollment and Payments to Medicaid

Assignment of Rights

This group health plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and Wellmark has a legal obligation to provide benefits for those services, Wellmark will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Medicaid Reimbursement

When a PPO or Participating provider submits a claim to a state Medicaid program for a covered service and Wellmark reimburses the state Medicaid program for the service, Wellmark's total payment for the service will be limited to the amount paid to the state Medicaid program. No additional payments will be made to the provider or to you.

Subrogation

For purposes of this "Subrogation" section, "third party" includes, but is not limited to, any of the following:

- The responsible person or that person's insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage;
- Personal umbrella coverage;
- Other insurance coverage including, but not limited to, homeowner's, motor vehicle, or medical payments insurance; and
- Any other payment from a source intended to compensate you for injuries resulting from an accident or alleged negligence.

Right of Subrogation

If you or your legal representative have a claim to recover money from a third party and this claim relates to an illness or injury for which this group health plan provides benefits, we, on behalf of your employer or group sponsor, will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

Right of Reimbursement

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

Once you receive benefits under this group health plan arising from an illness or injury, we will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any third party.

You agree to recognize our rights under this group health plan to subrogation and reimbursement. These rights provide us with a priority over any money paid by a third party to you relative to the amount paid by this group health plan, including priority over any claim for nonmedical charges, or other costs and expenses. We will assume all rights of recovery, to the extent of payment made under this group health plan, regardless of whether payment

is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement

You or your legal representative must do whatever we request with respect to the exercise of our subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform us in writing if you have an illness or injury caused by a third party or arising out of obligations you have under a contract. You or your legal representative must provide the following information, by registered mail, as soon as reasonably practicable of such illness or injury to us as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the illness or injury or is a party to the contract, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by us.

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue, Station 5W580
Des Moines, IA 50309-2901

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.
- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid under this group health plan in connection with the illness or injury) in trust for the benefit of this group health plan as trustee(s) for us until the extent of our right to reimbursement or subrogation has been resolved.
- In the event you invoke your rights of recovery against a third-party related to

the illness or injury, you will not seek an advancement of costs or fees from us.

- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses, and the "make whole" rule is specifically rejected and inapplicable under this group health plan.
- We will not be liable for payment of any share of attorneys' fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing, and the "common fund" rule is specifically rejected and inapplicable under this group health plan.

It is further agreed that in the event that you fail to take the necessary legal action to recover from the responsible party, we shall have the option to do so and may proceed in its name or your name against the responsible party and shall be entitled to the recovery of the amount of benefits paid under this group health plan and shall be entitled to recover its expenses, including reasonable attorney fees and costs, incurred for such recovery.

In the event we deem it necessary to institute legal action against you if you fail to repay us as required in this group health plan, you shall be liable for the amount of such payments made by us as well as all of our costs of collection, including reasonable attorney fees and costs.

You hereby authorize the deduction of any excess benefit received or benefits that should not have been paid, from any present or future compensation payments.

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

Our right of subrogation and reimbursement under this group health plan applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and reimbursement if there is any recovery on your claim.

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

Workers' Compensation

If you have received benefits under this group health plan for an injury or condition that is the subject or basis of a workers' compensation claim (whether litigated or not), we are entitled to reimbursement to the extent benefits are paid under this plan in the event that your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, we are entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. We will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

We utilize industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. We reserve the right to seek reimbursement of any such claim or to waive reimbursement of any claim, at our discretion.

Payment in Error

If for any reason we make payment in error, we may recover the amount we paid.

If we determine we did not make full payment, Wellmark will make the correct payment without interest.

Notice

If a specific address has not been provided elsewhere in this summary plan description, you may send any notice to Wellmark's home office:

Wellmark Blue Cross and Blue Shield of Iowa
1331 Grand Avenue
Des Moines, IA 50309-2901

Any notice from Wellmark to you is acceptable when sent to your address as it appears on Wellmark's records or the address of the group through which you are enrolled.

Submitting a Complaint

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

Consent to Telephone Calls and Text or Email Notifications

By enrolling in this employer sponsored group health plan, and providing your phone number and email address to your employer or to Wellmark, you give express consent to Wellmark to contact you using the email address or residential or cellular telephone number provided via live or pre-recorded voice call, or text message notification or email notification. Wellmark may contact you for purposes of providing important information about your plan and benefits, or to offer additional products and services related to your Wellmark plan. You may revoke this consent by following instructions given to you in the email, text or call notifications, or by telling the Wellmark representative that you no longer want to receive calls.

Glossary

The definitions in this section are terms that are used in various sections of this summary plan description. A term that appears in only one section is defined in that section.

Accidental Injury. An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

Admission. Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

Amount Charged. The amount that a provider bills for a service or supply or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

BlueCard Program. The Blue Cross Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of PPO Providers throughout the United States.

Compounded Drugs. Compounded prescription drugs are produced by combining, mixing, or altering ingredients by a pharmacist to create an alternate strength or dosage form tailored to the specialized medical needs of an individual patient when an FDA-approved drug is unavailable or a licensed health care provider decides that an FDA-approved drug is not appropriate for a patient's medical needs.

Continuing Care Patient is an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a serious or complex condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy, including postpartum care related to childbirth and delivery from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

Creditable Coverage. Any of the following categories of coverage:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health

coverage provided under a plan established or maintained by a foreign country or political subdivision).

- A health benefits plan under Section 5(e) of the Peace Corps Act.

Group. Those plan members who share a common relationship, such as employment or membership.

Group Sponsor. The entity that sponsors this group health plan.

Habilitative Services. Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Illness or Injury. Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

Inpatient. Services received, or a person receiving services, while admitted to a health care facility for at least an overnight stay.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

Medically Urgent. A situation where a longer, non-urgent response time could seriously jeopardize the life or health of the plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed without the services in question.

Medicare. The 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 Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member. A person covered under this group health plan.

Nonparticipating Pharmacy. A pharmacy that does not participate with the network used by your prescription drug benefits.

Office. An office setting is the room or rooms in which the practitioner or staff provide patient care.

Out-of-Network Provider. A facility or practitioner that does not participate with Wellmark or any other Blue Cross or Blue Shield Plan. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Outpatient. Services received, or a person receiving services, in the outpatient department of a hospital, an ambulatory surgery center, Licensed Psychiatric or Mental Health Treatment Facility, Licensed Substance Abuse Treatment Facility, or the home.

Participating Pharmacy. A pharmacy that participates with the network used by your prescription drug benefits. Pharmacies that do not contract with our pharmacy benefits manager are considered Out-of-Network Providers.

Participating Providers. These providers participate with a Blue Cross and/or Blue Shield Plan in another state or service area, but not with a preferred provider program. Pharmacies that contract with our pharmacy benefits manager are considered Participating Providers.

Plan. The group health benefits program offered to you as an eligible employee for purposes of ERISA.

Plan Administrator. The employer or group sponsor of this group health plan for purposes of the Employee Retirement Income Security Act.

Plan Member. The person who signed for this group health plan.

Plan Year. A date used for purposes of determining compliance with federal legislation.

PPO Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield preferred provider program.

Serious and Complex Condition. A condition, with respect to a participant, beneficiary, or enrollee under a group health plan or group or individual health insurance coverage:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that:
  - is life-threatening, degenerative, potentially disabling, or congenital; and
  - requires specialized medical care over a prolonged period of time.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this summary plan description, that may be used to diagnose or treat a medical condition.

Specialty Drugs. Drugs that are typically used for treating or managing chronic illnesses. These drugs are subject to restricted distribution by the U.S. Food and Drug Administration or require special handling, provider coordination, or patient education that may not be provided by a retail pharmacy. Some specialty drugs may be taken orally, but others may require administration by injection or inhalation.

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

Urgent Care Centers are classified by us as such in Iowa or South Dakota if they provide medical care without an appointment during all hours of operation to walk-in patients of all ages who are ill or injured and require immediate care but may not require the services of a hospital emergency room. For a list of Iowa or South Dakota facilities classified by Wellmark as Urgent Care Centers, please see the Wellmark Provider Directory.

We, Our, Us. Wellmark Blue Cross and Blue Shield of Iowa.

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

You, Your. The plan member and family members eligible for coverage under this group health plan.

Section IV

HRA Benefits

A. HRA Benefits

B. HRA Claim and Appeal Procedures

A. HRA Benefits

The purpose of the HRA Benefits is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and dependents' Health Care Expenses (defined below) that are not reimbursable from other sources. Reimbursements for Health Care Expenses paid by the HRA generally are excludable from taxable income.

1. **Health Care Expenses – Defined**
   Only Health Care Expenses are covered by the HRA. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether or not the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment. The Administrative Manager can provide you with more information about which expenses are eligible for reimbursement.

2. **HRA Benefits**
   Once you become a Participant, the Plan will maintain an HRA in your name to keep a record of the amounts available to you for the reimbursement of eligible Health Care Expenses. Your HRA is funded by contributions made by Contributing Employers. Some of those contributions are allocated as "premiums" for the other welfare benefits offered by the Plan, and your HRA is reduced monthly for those premium amounts. Whatever remains in your HRA after premium payments is available for reimbursement of Health Care Expenses that are not payable from the medical, dental or vision programs or any secondary source of health coverage. Those amounts are also available to cover periods when you would be subject to self-payment of contributions, as described in the *Eligibility and Participation* section of this SPD. HRA statements will be sent to Participants monthly.

   After the end of the Plan Year, the unused amount (if any) in your HRA generally will remain available in the next Plan Year, provided you are still a Participant (and subject to any election you may make to suspend or opt out of participation in the HRA).

3. **HRA Claims**
   Your HRA will reimburse you for eligible Health Care Expenses incurred by you, your Spouse, or your dependent(s) during the time you were a Participant under the Plan, to the extent that you have a positive balance in your HRA. Benefits must first be reimbursed from the medical, dental or vision benefits provided under the Plan and any secondary health insurance coverage before any benefits are payable from the HRA. Refer to the *HRA Claim and Appeal Procedures* section for instructions on submitting a claim for reimbursement from your HRA.

4. **HRA Limitations and Exclusions**
   Some examples of expenses that are not Health Care Expenses and are not eligible for reimbursement include the following:

   - Pregnancy testing kits.
   - OTC drugs or medicines that are purchased without a prescription. This exclusion does not apply to insulin, diabetic testing and supplies or to OTC drugs prescribed by a physician.
   - Health insurance premiums for any other plan maintained outside the Plan.
   - Long-term care services.
   - Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal

injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to a Participant's, Spouse's, or dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Menstrual care products.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code §213.
- Any expense incurred before you became a Participant.

5. **HRA Maximum**
Any balance remaining in the Participant's account at the end of the Plan Year will be rolled over to the next year to be used for recognized HRA withdrawals. There is no limit on the dollar amount accumulated in the HRA.

6. **HRA Opt-Out**
To satisfy the Affordable Care Act's requirements to keep your HRA benefit "integrated" with your medical benefit, you may elect to permanently opt out of and waive any right to reimbursements from your HRA by completing an opt-out form during each annual open enrollment that will take effect as of the beginning of the next Plan Year (January 1). In addition, a one-time opt-out of the HRA benefit is available upon the occurrence of any of the following events: (1) your termination of employment

or other loss of eligibility; (2) your becoming eligible for coverage under the Plan's Retiree Program; or (3) your death (for your surviving dependents).

If you elect to opt-out of your HRA, any amounts remaining in your account will be forfeited and will not be reinstated in the event you subsequently elect to re-enroll in the HRA benefit. Opting out of HRA coverage is generally advantageous only to individuals who wish to enroll in individual medical insurance coverage, including that offered through the government insurance Marketplace. If you wish to explore this option or obtain an "opt-out" form, please contact the Administrative Manager.

B. HRA Claim and Appeal Procedures

1. **Administration of HRA Claims and Appeals**
   The Administrative Manager is the Plan's HRA Claims Administrator and processes the Plan's HRA benefit claims and appeals. The Board of Trustees makes all final decisions on appeals.

2. **How to File a Claim for HRA Benefits**
   To file a claim for HRA benefits, an HRA claim form must be obtained from the HRA Claims Administrator, completed and submitted, with all required documentation, described below, to the HRA Claims Administrator at the address below:

   Auxiant
   Attn: Union Services
   P.O. Box 75008
   Cedar Rapids, IA 52407
   800-475-2232 ext. 1221

3. **Required Information and Documentation for HRA Benefit Claims**

   (a) The HRA claim form must include the following information:

   (i) The individual(s) on whose behalf the Health Care Expenses were incurred;

   (ii) The nature and date of the Health Care Expenses so incurred;

   (iii) The amount of the requested reimbursement; and

   (iv) A statement that such Health Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

   (b) Each HRA claim must be accompanied by bills, invoices, or other statements from an independent third party (*e.g.*, a hospital, physician, or pharmacy) showing that the Health Care Expenses have been incurred and showing the amounts of such Health Care Expenses, along with any additional documentation that the HRA Claims Administrator may request (including, but not limited to, proof of a prescription). Also, each claim for reimbursements made by other medical, dental or vision plan coverage must be accompanied by an Explanation of Benefits (EOB).

4. **When to File a Claim for HRA Benefits**
   Claims for HRA benefits must be received no later than the first day of the month, or the request will carry forward to the next month. Reimbursement requests will be processed around the 10th of the month. For example, a reimbursement request must be received by May 1 to be processed around May 10, and the check will be sent to you around May 15, along with your monthly HRA statement. The HRA Claims Administrator will process HRA reimbursements only once per month. Generally, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $100, although there is an exception made for the final reimbursement claim for a Plan Year.

5. **Additional Information on HRA Claims and Appeals**
   Please refer to the *General Claim and Appeal Procedures* section of this SPD for more information on HRA benefit claims and appeals.

Section V

Dental Benefits

A. Schedule of Dental Benefits
B. Dental Benefit Payment Information
C. Covered Dental Charges
D. Dental Limitations and Exclusions
E. Dental Notification Program
F. Dental Claim and Appeal Procedures
G. Dental Coordination of Benefits

A. Schedule of Dental Benefits

Schedule of Dental Benefits	
Deductible per Plan Year	
Per Covered Person	$50
Coinsurance Percentage Payable by the Plan	
Class I - Diagnostic and Preventive Services (Check-ups and Teeth Cleaning)	80% Deductible waived
Class II - Routine and Restorative Services, Endodontic Services and Periodontal Services (Cavity Repair and Tooth Extractions, Root Canals and Treatment of Gum and Bone Diseases)	80% after Deductible
Class III - High Cost Restoration Services and Prosthetics (Cast Restorations, Dentures and Bridges)	80% after Deductible
Class IV - Orthodontia (Services to Straighten Teeth)	50% after Deductible
Maximum Benefit Amount per Plan Year	
Covered Persons Under Age 18 Class I Services Class II and III Services Combined Covered Persons Age 18 and Over Classes I, II and III Services Combined	 Unlimited $1,500 $1,500
Maximum Benefit Amount per Lifetime for Class IV Services	$2,000

B. Dental Benefit Payment Information

1. **Dental Benefit Payment**
   Each Plan Year, the Plan will pay dental benefits for Covered Dental Charges incurred by a Covered Person after the Deductible amount has been satisfied, if applicable. Payment of dental benefits will be made at the rate shown under Coinsurance Percentage Payable by the Plan in the *Schedule of Dental Benefits* section. No dental benefits will be paid in excess of the Maximum Benefit Amount.

   If a service or procedure is covered by both the medical benefits and dental benefits provided by the Plan, medical benefits will be paid prior to dental benefits, if applicable, and benefits will not be coordinated between the two sets of benefits.

2. **Glossary of Dental Benefit Payment and Cost-Share Terms**
   The following definitions apply to the dental benefits section of this SPD only. To the extent that a different definition of the same term appears in another section this SPD, that definition will apply within that section.

   (a) **Billed Charge**
   The Billed Charge is the amount a dentist bills for a specific dental service or procedure.

   (b) **Coinsurance**
   Coinsurance is the percentage paid by the Plan for Covered Dental Charges. These amounts are shown under Coinsurance Percentage Payable by the Plan in the *Schedule of Dental Benefits* section . Coinsurance payments begin once any applicable Deductible amounts are met. In general, the percentage of Coinsurance you pay for a service depends on the Covered Dental Service class category.

   (c) **Covered Dental Charge**
   The Covered Dental Charge is the amount a dentist bills for a dentally necessary and appropriate Covered Dental Service, subject to the Maximum Plan Allowance.

   (d) **Date Charges Are Incurred**
   A dental charge is incurred on the date the service is performed or the date the dental appliance or material is furnished.

   (e) **Deductible**
   The Deductible is the fixed dollar amount you pay for Covered Dental Services for each Covered Person in a Plan Year before dental benefits are considered for payment by the Plan. This amount is shown in the *Schedule of Dental Benefits* section .

   (f) **Delta Dental's Payment Policy**
   Delta Dental's policy is to send payment for treatment after it is completed—not before.

   For example, Delta Dental will send payment for:

   - A crown when it is seated.
   - A fixed or removable prosthesis when it is inserted.
   - A root canal when it is filled.

(g) **Delta Dental Member Company**
A Delta Dental Member Company is a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Associations Bylaws.

(h) **Maximum Benefit Amount**
All payments for Covered Dental Services are limited to the Maximum Benefit Amount shown in the *Schedule of Dental Benefits* section for each Covered Dental Service class category. The Maximum Benefit Amount applies to each Covered Person separately.

The Maximum Benefit Amount for Orthodontic Services (Covered Dental Service Class IV) is determined on a Lifetime basis. It is not renewed if eligibility is lost and then reinstated at a later date. The Maximum Benefit Amount for all other Covered Dental Service class categories applies to each Plan Year and is renewed each January 1. Unutilized portions of the Maximum Benefit Amount in a Plan Year cannot be applied to increase the Maximum Benefit Amount for a different Plan Year.

(i) **Maximum Plan Allowance**
Maximum Plan Allowance is the amount Delta Dental establishes as the maximum allowable fee for specific Covered Dental Services provided under the Plan. For services billed by dentists outside of Iowa, the Maximum Plan Allowance is based on information from the Delta Dental Member Company in the applicable state. The Maximum Plan Allowance is established by Delta Dental for dental services contained in the "Current Dental Terminology" published by the American Dental Association from time to time. It is developed using various sources that may include, but are not limited to, contracts with dentists, the simplicity or complexity of a procedure, the Billed Charge for the same procedure by dentists in the same geographic area and with similar training and skills, and a leading economic indicator, such as the Consumer Price Index.

(j) **Plan Year**
A Plan Year is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1, provided you remain covered by the Plan. The Plan Year is important for determining when your Deductible has been met and Maximum Benefit Amounts.

3. **Delta Dental Network - What You Should Know About Selecting a Dentist**
You may seek care from almost any dentist you wish. However, there are usually advantages when you receive services from participating Delta Dental Dentists.

Your payment responsibilities are also outlined in this section of the SPD. How much you pay for a Covered Dental Service depends on the class category of the Covered Dental Service you receive and the dentist you receive the Covered Dental Service from. Most often, it is financially advantageous to you to receive Covered Dental Services from a Delta Dental Dentist.

4. **What You Should Know About Delta Dental Dentists**
Delta Dental has contracted relationships with Delta Dental Dentists throughout the state, which include payment arrangements that are made possible by Delta Dental's broad base of customers. Delta Dental uses different methods to determine payment arrangements. These payment arrangements usually result in savings to you. When you receive Covered Dental Services from Delta Dental Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

(a) Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangements, which may result in savings.

(b) Delta Dental Dentists agree to file claims for you.

(c) Delta Dental settles claims directly with Delta Dental Dentists. You are responsible for any Deductible and Coinsurance amounts you may owe. See the *Glossary of Dental Benefit Payment and Cost-Share Terms* section for more information.

(d) Delta Dental Dentists agree to handle the notification program for you. See the *Notification Program* section for more information.

(e) Delta Dental Dentists agree to be paid the lesser of (i) its Billed Charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Dental Services. Important: This does not apply in a situation where a service otherwise qualifying as a Covered Dental Service is provided and Delta Dental does not reimburse any part of such service. In such situation, the Delta Dental Dentist is not limited in the amount of the payment he or she may collect from you. See the *Understanding Payment Vocabulary* section for more information.

5. **What You Should Know About Dentists Who Do Not Participate With Delta Dental**

When you receive Covered Dental Services from nonparticipating (non-par) dentists, you will not receive any of the advantages that Delta Dental's contracts with Delta Dental Dentists offer. As a result, when you receive Covered Dental Services from nonparticipating dentists, all of the following statements are true:

(a) Delta Dental does not have contracting relationships with nonparticipating dentists and such dentists do not agree to accept local Delta Dental Member Company's payment arrangements. This means you are responsible for any difference between your nonparticipating dentist's Billed Charge and the Maximum Plan Allowance. See the *Understanding Payment Vocabulary* section for more information.

(b) Nonparticipating dentists are not responsible for filing your claims.

(c) Delta Dental does not settle claims directly with nonparticipating dentists; it settles claims with you. You are responsible for paying your dentist in full, including any deductible, coinsurance and non-approved charges you may owe. See the *Glossary of Dental Benefit Payment and Cost-Share Terms* section for more information.

(d) Nonparticipating dentists do not agree to handle the notification program for you. See the *Notification Program* section for more information.

(e) Nonparticipating dentists may charge for "infection control," which includes the costs for services and supplies associated with sterilization procedures. You are fully responsible for any extra charges billed by a nonparticipating dentist for "infection control"; such charges are not Covered Dental Services under the Plan. All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, Delta Dental Dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control."

(f) Nonparticipating dentists do not agree to only be paid the lesser of (i) its Billed Charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Dental Services, as Delta Dental Dentists do in certain situations. See *Glossary of Dental Benefit Payment and Cost-Share Terms* section for more information.

B. Dental Benefit Payment Information

6. **Determining Eligibility for Dental Services; Questions the Dental Claims Administrator May Ask Prior to Receiving a Dental Procedure**
Even though a dental service or procedure may appear in the *Covered Dental Services* section, the Dental Claims Administrator may first ask any of the questions below.

(a) **Is the Procedure Dentally Necessary?**
All of the following must be true for a procedure to be considered dentally necessary:

(i) The diagnosis is proper; and

(ii) The treatment is necessary to preserve or restore the basic form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

(b) **Is the Procedure Dentally Appropriate?**
All of the following must be true for a procedure to be considered dentally appropriate:

(i) The treatment is the most appropriate option for your individual circumstances; and

(ii) The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Delta Dental; and

(iii) The treatment is not more costly than alternative options that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. ***If you receive services that are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are fully responsible for paying the difference; such charges are not Covered Dental Services under the Plan.***

(c) **Is the Procedure Subject to Plan Limitations?**
Plan limitations refer to amounts that are your responsibility based on the design of your benefits under the Plan. Examples of Plan limitations include all of the following:

(i) Amounts for procedures that are not dentally necessary or dentally appropriate.

(ii) Amounts for procedures that are not Covered Dental Services under the Plan. See the *Dental Limitations and Exclusions* section for more information.

(iii) Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered twice per Plan Year. More frequent teeth cleaning is not a Covered Dental Service, even if your dentist verifies that it is dentally necessary and dentally appropriate. See *Covered Dental Services* section for a description of Covered Dental Services and associated limitations.

(iv) Amounts for procedures that have reached Plan maximums. See the *Schedule of Dental Benefits* section for more information.

(v) Any difference between the dentist's Billed Charge and the Maximum Plan Allowance, as the case may be. Please note: This only applies if you receive services from a nonparticipating dentist.

(vi) Deductible(s) and Coinsurance.

B. Dental Benefit Payment Information

7. **Treatment in Progress When Eligibility Terminates**
Generally, the Plan will not pay for services and supplies furnished after the date a Covered Person's eligibility for coverage under the Plan terminates.

The Plan will pay for services or supplies related to the following treatments if the treatment is rendered during the calendar month immediately after a Covered Person's eligibility termination date and the respective conditions are met:

(a) A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the individual was a Covered Person under the Plan;

(b) A crown if the dentist prepared the affected tooth for the crown while the individual was a Covered Person under the Plan;

(c) Root canal therapy if the dentist opened the affected tooth while the individual was a Covered Person under the Plan.

C. Covered Dental Services

The Plan pays dental benefits for the Covered Dental Charges made by a dentist or other Physician for the dentally necessary and appropriate Covered Dental Services as follows:

1. **CLASS I Covered Dental Services - Diagnostic and Preventive Services (Check-ups and Teeth Cleaning)**

   (a) Dental cleaning (prophylaxis) for removing plaque, tartar (calculus), and stain from the teeth. *Limited to twice per Plan Year.*

   (b) Routine oral exams. *Limited to twice per Plan Year.*

   (c) Bitewing x-rays. *Limited to twice per Plan Year (except when taken as a series of full-mouth x-rays, as described below).*

   (d) Occlusal x-rays, extraoral x-rays or periapical x-rays (radiographic images of a tooth or limited number of teeth that includes the crown and root portions).

   (e) Full-mouth x-rays – Either (i) a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date; or (ii) a panoramic x-ray. *Limited to once every three consecutive Plan Years.*

   (f) Topical fluoride applications. *Limited to Covered Persons under age 19, once per Plan Year.*

   (g) Sealant applications – Sealing the surface of molars to prevent decay. *Limited to Covered Persons under age 15, once per permanent and second molars, per Lifetime.*

   (h) Space maintainers for missing back teeth. *Limited to Covered Persons under age 19.*

2. **CLASS II Covered Dental Services - Routine and Restorative Services**

   (a) **Cavity Repair and Tooth Extractions**

      (i) Palliative treatment – Emergency treatment to relieve pain or infection of dental origin.

      (ii) Restoration of decayed or fractured teeth – Includes pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings and tooth-color (composite) fillings. *Limitation: If you choose a tooth-colored filling to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.*

      (iii) Occlusal Adjustment – Reshaping the biting surfaces of one or more teeth. *Limited to twice per Plan Year.*

      (iv) Routine oral surgery – Includes removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology or dysfunction of dental origin. *Limitation: General anesthesia/ sedation is covered only when provided in conjunction with covered oral surgery and when billed by the operating dentist.*

   (b) **Endodontic Services (Root Canals)**

      (i) Apicoectomy/periradicular surgery – Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

(ii) Direct pulp cap – Covering exposed pulp with a dressing or cement to protect it and promote healing and repair.

(iii) Pulpotomy – Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

(iv) Retrograde fillings – Sealing the root canal by preparing and filling it from the root end of the tooth.

(v) Root canal therapy – Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

(c) **Periodontal Services (Treatment of Gum and Bone Diseases)**
Please Note: Procedures in this category should be reviewed by the Dental Claims Administrator *before* they are performed. See *The Notification Program* section.

(i) Full Mouth debridement. *Limited to once per Lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).*

(ii) Conservative periodontal procedures (root plaining and scaling) – Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it. *Limited to once every 24 consecutive months for each quadrant of the mouth.*

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

(iii) Complex periodontal procedures – Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth. *Limited to once every 36 consecutive months for each quadrant of the mouth for natural teeth only.*

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

(iv) Periodontal maintenance therapy – Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling. *Limitation: This procedure may follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, benefits are available up to four times in the first Plan Year and twice per Plan Year thereafter. This procedure replaces the dental cleaning benefit (prophylaxis) described under the CLASS I Covered Dental Services – Diagnostic and Preventive Services section above.*

3. **<u>CLASS III Covered Dental Services - Major Restorative Services</u>**

(a) **High Cost Restorations - Cast Restorations**

Limitation: Procedures in this category are available once every five consecutive years beginning from the date the cast restoration is cemented in place.

(i) Cast restorations for complicated tooth decay or fracture – Restoring a tooth with a cast filing (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth-colored composite filling.

(ii) Crowns – Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Limitation: Crowns are a Covered Dental Service only if the tooth cannot be restored with a routine filling. Dental Benefits paid for crowns supported by surgically placed dental implants will be limited to the amount paid for a conventional, natural tooth supported crown. Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition abrasion, erosion, and abfraction are not a Covered Dental Service.* Prior to January 1, 2020, dental implants were not a Covered Dental Service.

(iii) Inlays – Restoring a tooth with a cast metallic or porcelain filling. *Limited to the amount paid for a silver (amalgam) filling.*

(iv) Onlays – Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.

(v) Posts and cores – Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

(vi) Recementation of cast restorations. *Limited to once every 12 consecutive months after 6 months have elapsed since initial placement.*

(b) **Prosthetics (Dentures and Bridges)**

Limitation: Procedures in this category are available once every five consecutive years.

(i) Bridges – Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs. *Limitation: Bridges that are supported by dental implants will be limited to the amount paid for a bridge supported by natural teeth.* Prior to January 1, 2020, dental implants were not a Covered Dental Service.

(ii) Dentures (complete and partial) – Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered. *Limitation: Dentures that are supported by surgically placed dental implants will be limited to the amount paid for a conventional, natural-teeth-supported prosthesis.* Prior to January 1, 2020, dental implants were not a Covered Dental Service.

(iii) Denture adjustments. *Limited to two per denture per Plan Year after 6 months have elapsed since initial placement.*

(iv) Tissue conditioning. *Limited to two per denture every 36 consecutive months.*

(v) Dental implants. *Limited to one implant per tooth, per five consecutive years.* Prior to January 1, 2020, dental implants were not a Covered Dental Service.

4. **CLASS IV Covered Dental Services - Orthodontics (Services to Straighten Teeth)**
Orthodontics is treatment that moves teeth by means of appliances that correct a handicapping malocclusion of the mouth.

(a) Diagnostic procedures – Includes cephalometric x-rays and diagnostic cast.

(b) Appliance therapy (braces) – Includes related periodic oral exams and adjustments.

When an orthodontic treatment plan is established, the Dental Claims Administrator will calculate an initial payment at the time the banding takes place. Payment for treatment in progress extends only to the months of treatment received while covered under the Plan. The Dental Claims Administrator will determine the months eligible for dental benefits under the Plan. The balance of the allowed fee will then be divided into payments over the course of treatment, provided dental benefits under the Plan continue to be in effect.

Alternatively, payment for a Covered Person's full course of treatment may be made to the service provider in advance, then proof of payment may be submitted to the Dental Claims Administrator, and the Dental Claims Administrator will manually price and reimburse the full amount of benefits at that time.

D. Dental Limitations and Exclusions

No benefits will be payable for the following dental expenses:

1. **Administrative costs:** Includes completing claim forms or reports or for providing dental records.
2. **Anesthesia or analgesia:** Includes charges for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the dental procedure performed.
3. **Broken appointments:** Includes charges for broken or missed dental appointments.
4. **Close relative dentists:** Includes charges for services or supplies provided by a dentist who is a close relative (e.g., spouse, parent, sibling or in-law of a Covered Person).
5. **Complete occlusal adjustment**: Includes charges for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.
6. **Complications caused by a non-Covered Dental Service**.
7. **Congenital deformities:** Includes charges for services or supplies used to correct congenital deformities, such as a cleft palate.
8. **Controlled release devices:** Includes charges for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.
9. **Cosmetic dentistry:** Includes charges for services or supplies primarily used for improving the appearance of teeth, rather than restoring or improving dental form or function. Some examples include: laminate and veneers, teeth whitening or personalization or characterization of prosthetics.
10. **Desensitizing medicament or resin:** Includes charges for application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
11. **Drugs:** Includes charges for prescription or non-prescription drugs or medicines (see the *Prescription Drug Benefit* section for more information).
12. **Experimental or Investigative:** Includes charges for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.
13. **Government program:** Includes charges for dental services or supplies that Covered Persons are entitled to claim from any governmental program (except Medicaid) even if the Covered Person waived or failed to claim rights to such services, benefits or damages.
14. **Guided tissue regeneration:** Includes charges for services or supplies to encourage regeneration of lost periodontal structures.
15. **Incomplete services:** Includes charges for dental services that have not been completed.
16. **Indirect pulp caps.**
17. **Infection control:** Includes any separate charges for "infection control," which includes the cost for services and supplies associated with sterilization procedures.
18. **Lost or stolen appliances or devices:** Includes charges for any services or supplies required to replace lost or stolen dental appliances or prosthetic devices.
19. **Medical services or supplies:** Includes services or supplies that are medical in nature, such as dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and Accidental Injuries (see the *Medical Benefits* section for more information).

D. Dental Limitations and Exclusions

20. **Medical or dental department maintained by an employer:** Includes dental services rendered through a medical or dental department, clinic or similar facility provided or maintained by the Covered Person's employer.
21. **Myofunction therapy:** Includes charges for myofunction therapy (correction of harmful habits such as thumbsucking).
22. **Non-Dentist provider:** Includes treatment provided by an individual who is not a licensed dentist or licensed Physician; however, scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by a dentist.
23. **Not dentally necessary:** Includes dental services or supplies that are not dentally necessary according to accepted standards of dental practice.
24. **Not legally obligated to pay:** Includes charges for dental services or supplies that a Covered Person is not legally obligated to pay for and for which a Covered Person would not be charged in the absence of coverage under the Plan.
25. **Occupational:** Includes charges for any dental services or supplies that may be or could have been compensated under workers' compensation laws, including any services or supplies applied toward the satisfaction of any deductible under an employer's workers' compensation coverage.
26. **Oral hygiene program:** Includes charges for oral hygiene, dietary instruction or plaque control programs.
27. **Periodontal appliances:** Includes charges for services or supplies related to dental appliances, including night guards for the treatment of gum and bone disease or to limit tooth grinding or jaw clenching.
28. **Periodontal splinting:** Includes charges for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.
29. **Repair, replacement or duplication:** Includes charges for repair, replacement or duplication of any orthodontic appliance.
30. **Services before coverage:** Includes charges for any dental services rendered, supplies ordered or treatment plan otherwise commenced before a Covered Person's coverage under the Plan became effective.
31. **Specialized services:** Includes charges for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.
32. **Splinting:** Includes crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are otherwise cosmetic.
33. **Temporary or interim procedures:** Includes charges for provisional crowns, bridges or dentures.
34. **Termination:** Includes charges for dental services or supplies received after the date a previously-Covered Person's coverage under the Plan terminates, except as specifically noted above (see *Treatment in Progress When Eligibility Terminates* section.
35. **TMJ:** Includes non-surgical treatment, procedures or appliances related to the treatment of temporomandibular joint disorders.

D. Dental Limitations and Exclusions

36. **Unerupted teeth:** Includes charges for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means the Dental Claims Administrator will not pay for the removal of any tooth that is not visible and not causing harm.

E. Dental Notification Program

This section explains the dental notification program you and your dentist should follow before you receive certain dental benefits under the Plan. This program serves as the checks and balances of your dental coverage. It helps:

- Determine that services are dentally necessary and dentally appropriate; and
- Confirm the dental benefits are available under the Plan.

1. **Approval for Certain Dental Benefits**
   The purpose of the notification program is to help control the cost of your benefits—not to keep you from receiving dentally necessary and dentally appropriate treatment.

   You should notify the Dental Claims Administrator before you undergo any of the following treatments:

   - Periodontal treatment for gum and bone disease
   - High cost restorations
   - Bridges and dentures

   You should also notify the Dental Claims Administrator before you receive treatment from any Covered Dental Service class that will exceed $200.

   The Dental Claims Administrator's review is based on the treatment plan submitted by your dentist.

2. **The Treatment Plan**
   A treatment plan describes the treatment your dentist has recommended for you and helps the Dental Claims Administrator determine if the procedure is a Covered Dental Service under the Plan, as well as dentally necessary and dentally appropriate.

3. **When to Submit a Treatment Plan**
   You will need to file a proposed treatment plan only if your dentist is a nonparticipating dentist — Delta Dental Dentists agree to file for you.

   A complete treatment plan includes the plan of treatment (including supporting information) and x-rays. Please send the x-rays within 15 working days of filing your proposed treatment plan.

4. **Where to Send a Treatment Plan**
   Submit the proposed treatment plan, along with x-rays and supporting information to:

   Delta Dental of Iowa
   P.O. Box 9000
   Johnston, IA 50131-9000

5. **The Treatment Plan Review**
   Once the Dental Claims Administrator receives the proposed treatment plan and proper documentation, the Dental Claims Administrator will let you and your dentist know if the treatment plan is approved within 15 working days. The Dental Claims Administrator will take one of the following three actions after they receive and review your treatment plan:

E. Dental Notification Program

- *Accept* it as submitted.
- *Recommend an alternative benefit*.
- *Deny the treatment plan* because:
  - The procedure is not a Covered Dental Service under the Plan; or
  - The procedure is not dentally necessary and dentally appropriate.

Please note: Although the Dental Claims Administrator may approve a treatment plan, neither the Dental Claims Administrator nor the Plan are necessarily liable for the actual treatment you receive from your dentist.

F. Dental Claim and Appeal Procedures

1. **Administration of Dental Claims Procedures**
   Delta Dental is the Plan's Dental Claims Administrator and processes the Plan's dental benefit claims and appeals. The Board of Trustees makes all final decisions on appeals.

2. **How to File a Claim for Dental Benefits**
   Participating Delta Dental Dentists will file claims on your behalf.

   If you need a claim form or have any questions after reading this section, please call Delta Dental or visit their website www.deltadental.com. If you must file your own claim, send it to the following address:

   Delta Dental of Iowa
   P.O. Box 9000
   Johnston, IA 50131-9000

3. **When to File a Claim for Dental Benefits**
   After you receive services, you should file a claim only if your dentist has not filed one for you. Claims must be filed within one year after the date services were rendered.

   You should file a claim only after the procedure is completely finished. Do not file a claim before a procedure is completed.

4. **How to Review Relevant Documents, Records and Other Information**
   Upon request, you can review documents, records and other information relevant (as described in the *Relevant Documents, Records and Other Information* section to your claim from 8 a.m. to 4:30 p.m., Central Time, Monday through Friday, at Delta Dental's Johnston, Iowa location. Since Delta Dental maintains many of these records in electronic form, please call or write to Delta Dental in advance so they can have paper copies of these records available for your review.

   Send your request to:

   Delta Dental of Iowa
   P.O. Box 9000
   Johnston, IA 50131-9000

5. **Additional Information on Dental Claims and Appeals**
   Please refer to the *General Claim and Appeal Procedures* section of this SPD for more information on dental benefit claims and appeals.

G. Dental Coordination of Benefits

1. **General Information**
   You may have other insurance or coverage that provides the same or similar benefit(s) as this Plan's dental benefit. If so, Delta Dental will work with your other insurance company or carrier or health plan. The benefits payable under this Plan when combined with the benefits paid under your other coverage will not be more than 100 percent of either Delta Dental's payment arrangement amount or the other carrier's or health plan's payment arrangement amount.

2. **What You Must Do**
   When you receive services, you need to let Delta Dental know that you have other coverage. Other coverage includes: group insurance, other group benefit plans (such as HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no-fault basis). To help Delta Dental coordinate your benefits, you must:

   - Inform your dentist by giving him or her information about your other coverage at the time you receive services. Your dentist will pass the information on to Delta Dental when the claim is filed.
   - Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. Delta Dental will contact you if any additional information is needed.

   You must cooperate with Delta Dental and provide requested information about your other coverage. If you do not give Delta Dental necessary information, your claims will be denied.

3. **What Delta Dental Will Do**
   There are certain rules Delta Dental follows to help determine which coverage pays first when you have other insurance or coverage that provides the same or similar benefits as this Plan. Here are some of the rules:

   - The coverage without coordination of benefits pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
   - The dental benefits of your auto coverage will pay before this coverage if the auto coverage does not have a coordination of benefits provision.
   - The coverage which you have as an employee or contract holder participant pays before the coverage which you have as a plan beneficiary spouse or child.
   - The coverage you have as the result of your active employment pays before coverage you hold as a retiree or under which you are not actively employed.
   - The coverage with the earliest continuous effective date pays first when none of the above rules apply.

   If none of the guidelines just mentioned apply to your situation, Delta Dental will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine payment to you or to your PPO Panel Dentist or Participating Delta Dental Dentist (as the case may be).

4. **What You Should Know About Beneficiaries Who Are Children**
   To coordinate benefits for a child the following rules apply. For a child who is:

   - Covered by both parents who are not separated or divorced or if they are, neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar

year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.

- Covered by separated or divorced parents and a court decree says which parent has financial or dental insurance responsibility, that parent's coverage pays first.
- Covered by separated or divorced parents and a court decree does not stipulate which parent has financial or dental insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this child is as follows: custodial parent, spouse of custodial parent, other parent, and spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

Section VI

Vision Care Benefits

A. Schedule of Vision Care Benefits
B. Vision Care Benefits
C. Vision Claim and Appeal Procedures

A. Schedule of Vision Care Benefits

Schedule of Vision Care Benefits	
DeltaVision Discount Plan[1]	
Vision Care Services	**Your Cost at EyeMed Access Network Provider**
Exam and dilation as necessary	$5 off routine exam $5 off contact lens exam
Complete pair of glasses purchase[2]: Frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard plastic lenses:	
Single vision	$50
Bifocal	$70
Trifocal	$105
Frames	35% off retail price
Lens options:	
UV treatment	$15
Tint (solid and gradient)	$15
Standard plastic scratch coating	$15
Standard polycarbonate	$40
Standard progressive lens (add-on to bifocal)	$65
Standard anti-reflective coating	$45
Other add-ons and services	20% off retail price
Contact lens materials: (discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser vision correction[3]: LASIK or PRK	15% off retail price or 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact lenses	Unlimited

A. Schedule of Vision Care Benefits

Reimbursement Benefit (Administered by Auxiant)	
Vision Care Services	**Amount**
Eye examination, one per Plan Year	Covered up to $150
Eyeglass frames, lenses and lens options[4]	Covered up to $150 per Plan Year
Contact lenses (materials only)[4]:	
Conventional	Covered up to $150 per Plan Year
Disposable	Covered up to $150 per Plan Year
Medically necessary[5]	Covered up to $210 per Plan Year
Prescription Safety Glasses (for the Employee only)	Covered up to $150 per Plan Year

[1] The DeltaVision Discount Plan discounts shown in the *Schedule of Vision Care Benefits* may not be combined with any other provider discounts or promotional offers. You will receive a 20% discount on those items purchased at participating providers that are not specifically covered by this discount, except discounts do not apply to EyeMed provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy. Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered. Retail prices may vary by location.

[2] Items purchased separately will be discounted 20% off of the retail price.

[3] Since LASIK and PRK vision corrections are elective procedures, performed by specially trained providers, this discount may not always be available from a provider in your location. For a location near you and the discount authorization, please call 1.877.5LASER6.

[4] One set of frames and lenses OR one regimen of contacts (but not both) covered in a 12 month period.

[5] The Plan provides the reimbursement benefit for medically necessary contact lenses when one of the following conditions exists:

- Anisometropia of 3D in meridian powers;
- High Ametropia exceeding –10D or +10D in meridian powers;
- Keratoconus where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses; or
- Vision Improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

B. Vision Care Benefits – Coverage Details

Vision care benefits under the Plan apply only when vision care charges are incurred by a Covered Person for vision-related services that are recommended and approved by a Physician, Optometrist or Optician. Vision care benefits will be payable for vision care services and supplies as outlined in the *Schedule of Vision Care Benefits* section.

1. **DeltaVision Discount Plan Using the EyeMed Access Network**
   To obtain the DeltaVision Discount Plan discounts on vision services described in the *Schedule of Vision Care Benefits* section, you must use a provider participating in the EyeMed Access panel of providers. EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, such as LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed vision care providers near you, visit www.eyemed.com and choose the Access Network or call 1-800-521-3605.

2. **Providers**

   (a) **EyeMed Access Network Provider**: If you wish to use the DeltaVision Discount Plan, confirm the provider participates in the EyeMed Access Network. Let the provider know you have a discount through DeltaVision and provide your name and your discount plan number, located on the front of your DeltaVision discount card. While your DeltaVision discount card is not necessary to receive services, it is helpful to present your DeltaVision discount card to identify your membership in the DeltaVision Discount Plan. In addition, it may be helpful to show your Dental/Vision/Pharmacy ID card to the provider; some providers will submit a claim directly to Auxiant.

   When you receive services at a participating EyeMed Access Network Provider, the provider will apply the DeltaVision discount and you will have to pay the cost of any services or eyewear that exceeds any discounts (unless the provider submits a claim to Auxiant directly). You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training). You may be reimbursed as outlined in the *Reimbursement Benefits* section below.

   (b) **Out-of-Network Provider**: If you receive services from an out-of-network provider, you will pay the full cost at the point of service. You may be reimbursed as outlined in the *Reimbursement Benefits* section below.

3. **Reimbursement Benefits**

To receive reimbursement from the Plan up to the maximums as outlined in the *Schedule of Vision Care Benefits* section, complete and sign a vision claim form, attach your itemized receipts and send to Auxiant. Refer to the *Vision Care Claim and Appeal Procedures* section below for details.

4. **DeltaVision Discount Plan Limitations/Exclusions**
   No discounts will be available for the following:

   (a) Charges for vision services or supplies incurred before a Covered Person was covered under the Plan or after coverage terminates.

   (b) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing.

   (c) Medical and/or surgical treatment of the eye, eyes or supporting structures.

   (d) Corrective eyewear required by an employer as a condition of employment and safety eyewear.

   (e) Services provided as a result of any workers' compensation law.

B. Vision Care Benefits – Coverage Details

5. **Reimbursement Benefit Limitations/Exclusions**
No reimbursement benefits will be payable for the following:

(a) **Before or after coverage:** Includes charges for vision services or supplies incurred before a Covered Person was covered under the Plan or after coverage terminates.

(b) **Frequency:** Includes charges for vision examinations or materials received more frequently than the the Plan covers.

(c) **Medical plan:** Includes charges that are covered under a medical plan that reimburses a greater amount for vision care expenses than the Plan.

(d) **Medical and surgical treatment:** Includes charges for services, treatment or supplies related to medical or surgical treatment of the eyes or supporting structures.

(e) **No prescription:** Includes charges for lenses obtained without a prescription.

(f) **Replacement:** Includes charges for lenses, frames or contact lenses that are lost or broken, except at the normal intervals (*i.e.*, Plan Year) when benefits are available.

(g) **Special procedures:** Includes charges for special procedures such as orthoptics, vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.

(h) **Safety glasses:** Includes charges for safety glasses for a Covered Person other than the Employee covered under the Plan.

(i) **Bifocal substitute:** Charges for two pairs of glasses in lieu of bifocals.

(j) **Workers' compensation:** Includes charges for services that are or would be compensable under any workers' compensation law or similar legislation.

C. Vision Care Claim and Appeal Procedures

1. **Administration of Vision Reimbursement Benefit Claims Procedures**
   The Administrative Manager (Auxiant) is the Plan's Vision Claims Administrator and processes the Plan's vision care reimbursement benefit claims and appeals. The Board of Trustees makes all final decisions on appeals.

2. **How to File a Claim for Vision Care Reimbursement Benefits**
   To file a claim for vision care reimbursement benefits, a vision claim form must be obtained from the Vision Claims Administrator, completed and submitted, with an itemized receipt from the service provider, to the Vision Claims Administrator at the address below.

   Auxiant
   Attn: Union Services
   P.O. Box 75008
   Cedar Rapids, IA 52407
   800-475-2232 ext. 1299

   Some service providers may submit your claim for vision care benefits directly to the Vision Claims Administrator.

3. **When to File a Claim for Vision Benefits**
   After you receive vision care services, you should file a claim, unless your service provider has filed a claim directly with the Vision Claims Administrator for you. Claims must be filed within one year after the date services were rendered.

4. **Additional Information on Vision Claims and Appeals**
   Please refer to the *General Claim and Appeal Procedures* section of this SPD for more information on vision care reimbursement benefit claims and appeals.

Section VII

Employee Assistance Program ("EAP") Benefits

A. Employee Assistance Program Benefits

A. Employee Assistance Program Benefits

1. **Schedule of EAP Benefits**

Schedule of EAP Benefits
Benefits Included
• Five assessment and/or counseling sessions per family member, per EAP benefit determination period • One half-hour legal consultation (by referral) per EAP benefit determination period (available in Cedar Rapids metro area only) • One hour financial consultation (by referral) per EAP benefit determination period (available in Cedar Rapids metro area only)
Please Note: The EAP benefit determination period does not follow the Plan Year (*i.e.*, calendar year determination period). The EAP benefit determination period begins on June 1 and ends on May 31.

2. **General**

The Employee Assistance Program ("EAP") benefit is comprised of a confidential assessment, counseling, and referral service, and is available to Participants and covered dependents for assistance with problems that affect their personal lives, such as relationships, family, work, emotional health, mental health, and substance abuse concerns. The Board of Trustees has contracted with an EAP provider (Mercy Family Counsel & Employee Assistance Program ("Mercy")), which is an organization of experienced, licensed mental health counselors and social workers to provide confidential, professional assistance to deal with personal problems that may be affecting life at home and at work.

3. **Types of Assistance**

The Plan's EAP benefits may include, but are not limited to, treatment of the following:

- Anxiety
- Anger
- Communication skills
- Depression
- Divorce, blended families and co-parenting
- Emotional/mental health concerns
- Grief/loss
- Resolving conflict(s)
- Stress
- Trauma/abuse
- Work/career concerns
- Alcohol/drug abuse
- Financial and legal counseling (available by referral in the Cedar Rapids metro area)

A. Employee Assistance Program Benefits

If services are required beyond the assessment and counseling sessions, Mercy will assist you in finding a network provider to maximize your Plan benefits.

4. **Utilization**
Participants and covered dependents may seek to utilize the EAP benefits voluntarily or by mandate (*e.g.*, in the event of a positive alcohol or drug screening) by contacting Mercy directly by telephone: 319-398-6694 (local) or 800-383-6694 (toll-free). Appointments are offered at eight locations. More information is available at www.mercycare.org/EAP.

Section VIII

Short Term Disability Benefits

A. Short Term Disability Benefits

B. Short Term Disability Benefits Claim and Appeal Procedures

A. Short Term Disability Benefits

1. **Schedule of Short Term Disability Benefits**

Schedule of Short Term Disability Benefits	
Short Term Disability Benefit	50% of Employee's contracted hourly rate multiplied by 40 hours, limited to a maximum of 50% of an I.B.E.W. Local 405 Journeyman's wage (based on a 40 hour work week).
Waiting Period (Not Included in the Maximum Period of Payment)	
Disability due to Illness or Injury	14 days Payment to begin on the 15th day of Total Disability
Maximum Period of Payment	26 weeks

2. **Eligibility for Short Term Disability Benefits**
All Bargaining Unit Employees are eligible for short term disability benefits. Non-Bargaining Unit Employees may be eligible for short term disability benefits if these benefits have been elected by their Contributing Employer.

3. **Requirements for Short Term Disability Benefits**
This benefit applies when a Participant has a Total Disability that meets all of the following tests:

   (a) Total Disability starts while the Participant is covered for this benefit. Participant is covered for this benefit as outlined in the *Eligibility and Participation* section of this SPD, including during periods of self-payment of contributions.

   (b) Total Disability is being continuously treated by a Physician (a chiropractor is not considered a Physician for the purpose of disability benefits).

   (c) Total Disability is due to Illness or Injury that, in either case, is non-occupational -- that is, did not arise from work for wage or profit.

   (d) Total Disability (Totally Disabled) means your inability, due to Illness or Injury, to perform substantially all of the material duties of your regular job, including regular attendance on a full-time basis.

4. **Proof of Total Disability**
The Plan will reserve the option of requesting periodic physical examinations from either the Participant's current Physician or a Physician of the Trustees' choice. Failure to provide requested Physicians' statements certifying continued Total Disability will result in termination of short term disability benefits. Participants are responsible for providing the following information in a clear and

understandable format:

(a) History of Total Disability (first appearance of symptoms or description of Accidental Injury);

(b) Diagnosis;

(c) Dates of treatment;

(d) Nature of treatment;

(e) Progress;

(f) Prognosis;

(g) Suitability for rehabilitation; and

(h) Physician's signature and tax I.D. number.

Additional information may be required based upon the individual Illness or Injury.

5. **Benefit Payment**
Benefits will be paid for a Total Disability in an amount not to exceed the limits set forth in the *Schedule of Short Term Disability Benefits*.

Benefits for a Period of Total Disability will end at the earlier of the date the Employee is no longer Totally Disabled, or the date the Employee reaches the Maximum Period of Payment as shown in the Schedule of Benefits, regardless of whether the Employee's active employment terminates during the Period of Total Disability.

6. **Period of Total Disability**
Period of Total Disability is the period of time that an Employee is Totally Disabled. Subsequent Periods of Total Disability due to the same or related causes must be separated by return to "active work" (i.e., performing all of the regular duties of the Employee's occupation), for at least 250 hours of work in 3 consecutive calendar months, or 500 hours of work in 6 consecutive calendar months. Subsequent Periods of Total Disability due to different causes must be separated by return to active work for at least one day.

7. **Short Term Disability Limitations and Exclusions**
No short term disability benefits are payable:

(a) Until you have seen and been certified as Totally Disabled by a Physician;

(b) For any period during which you are not under the regular care of a Physician;

(c) For any days for which you receive holiday or vacation pay during a Period of Total Disability;

(d) For any period during which you are Totally Disabled as a result of being engaged in an activity primarily for wage, profit or gain, or that could entitle you to benefits under a workers' compensation law or similar legislation;

(e) For any period during which you are Totally Disabled as a result of engaging in an illegal occupation; committing or attempting to commit an illegal act; participating in a civil insurrection or riot; performing your duty as a member of the armed forces of any state or country; or war or act of war which is declared or undeclared.

(f) For any period during which you are performing work for compensation or profit.

(g) For any period during which you are Totally Disabled as a result of being under the influence of intoxicants or a controlled substance not administered under the advice of a physician.

(h) For any period during which you are incarcerated.

B. Short Term Disability Claim and Appeal Procedures

1. **Administration of Short Term Disability Claims Procedures**
   The Administrative Manager (Auxiant) is the Plan's Short Term Disability Claims Administrator and processes the Plan's short term disability benefit claims and appeals. The Board of Trustees makes all final decisions on appeals.

2. **How to File a Claim for Short Term Disability Benefits**
   To file a claim for short term disability benefits, a short term disability claim form must be obtained from the Short Term Disability Claims Administrator. To complete the form, you must:

   (a) Complete the employee portion of the form;

   (b) Have your employer or the I.B.E.W. Local 405 Union Office complete its portion of the form to verify your employment status; and

   (c) Have your attending Physician complete his or her portion of the form to certify your Total Disability; and

   (d) Submit the form, with all required documentation to the Short Term Disability Claims Administrator at the address below:

   AuxiantP.O. Box 75008
   Cedar Rapids, IA 52407
   800-475-2232 ext. 1220

3. **When to File a Claim for Short Term Disability Benefits**
   Completed forms must be filed promptly with the Short Term Disability Claims Administrator at the address below, preferably no more than 21 days after the period of Total Disability begins. The Trustees may require that your continuing Total Disability be re-certified periodically by your Physician.

6. **Additional Information on Short Term Disability Claims and Appeals**
   Please refer to the *General Claim and Appeal Procedures* section of this SPD for more information on short term disability benefit claims and appeals.

Section IX

Life Insurance Benefits

and

Accidental Death and Dismemberment Insurance (AD&D) Benefits

A. Schedule of Life and AD&D Benefits

Schedule of Life and AD&D Benefits	
Life Insurance Benefit:	Principal Sum: $10,000
Accidental Death and Dismemberment (AD&D) Benefits	Principal Sum: $10,000 Life ..... Principal Sum Both hands..... Principal Sum Both feet..... Principal Sum Both eyes..... Principal Sum One hand and one foot ..... Principal Sum One hand and one eye ..... Principal Sum One hand ..... 50% of Principal Sum One foot..... 50% of Principal Sum One eye ..... 50% of Principal Sum

B. Life Insurance Benefits

Life insurance benefits under the Plan are provided under a policy or group insurance issued to the Trustees. This section summarizes the main provisions of the master policy and individual certificates issued by such insurance company. In all cases, the master policy or certificate of insurance will govern life insurance benefit payments.

1. **General**
   If a Participant dies from any cause, a life insurance benefit is payable in the amount specified in the *Schedule of Life and AD&D Benefits* section. Acceptable proof of death, as determined by the life insurance carrier, must be provided to the Administrative Manager in order for benefits to be paid.

2. **Beneficiary Designation**
   A Participant must file a written designation of beneficiary with the Administrative Manager, using a properly completed Designation of Beneficiary form, provided by the Administrative Manager. The Participant may change his or her beneficiary designation by filing a new, properly completed Designation of Beneficiary form with the Administrative Manager. If the Participant is married and wishes to designate a beneficiary other than the Participant's Spouse, the Participant's Spouse must provide written consent to such designation of beneficiary, unless the Participant's Spouse previously expressly permitted subsequent designations of beneficiary without further consent. A Participant may change his or her beneficiary designation at any time, but the designation must be on file with the Administrative Manager prior to the Participant's death in order to be valid.

   In the event a Participant designated his or her former spouse as his or her beneficiary and such marriage was legally terminated by divorce, any prior designation of beneficiary naming such former spouse as beneficiary will be deemed to be null and void. If the Participant wishes to again name his or her former spouse as beneficiary, the Participant must complete a new Designation of Beneficiary form listing the former spouse as beneficiary following the divorce and file such form with the Administrative Manager.

   If more than one beneficiary is named, but the Participant did not designate the order of beneficiary rights, the beneficiaries will share equally. The share of a beneficiary who does not survive the Participant will be passed to any surviving beneficiaries in the order designated. If the Participant does not designate a beneficiary or if the Participant's beneficiary does not survive the Participant, or if the Designation of Beneficiary form is otherwise invalid, the Participant's life insurance benefit will be paid to the Participant's surviving Spouse or, if none, to the Participant's surviving biological or legally adopted child or children, in equal shares or, if none, to the Participant's surviving parents, in equal shares, or if none, to the Participant's surviving siblings, in equal shares, or if none, to the Participant's estate or personal representative if there is no estate.

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3. **How Life Insurance Benefits are Paid**
   Life insurance benefit payments will be payable in a lump sum as soon as administratively feasible after the required documentation is submitted to the Administrative Manager. If two or more beneficiaries are entitled to the Participant's life insurance benefit, each beneficiary will share the life insurance benefit equally, unless specified differently on the Participant's Designation of Beneficiary form on file with the Administrative Manager.

4. **Continuation of Coverage During Total Disability (Waiver of Premium)**
   Life insurance coverage will continue without further payment of premiums while a Participant is Totally Disabled if the following conditions are met:

   (a) The Participant became Totally Disabled while covered by the Plan and before reaching age 60;

(b) The Participant has been Totally Disabled for at least 9 months;

(c) The Participant or his/her representative notifies the Administrative Manager of the Total Disability within one year from the date the Total Disability started; and

(d) The Participant provides proof to the Administrative Manager of his/her continuous Total Disability. Proof must be provided between the 8th and 9th month after the date the Total Disability started, and continuing proof of Total Disability must be given as required by the insurance carrier.

For purposes of this provision, "Total Disability" or "Totally Disabled" means that as a result of Illness or Injury, the Participant is unable to perform each of the material duties of any gainful occupation for which he/she is reasonably fitted by training, education or experience.

5. **Notice of Claim During Total Disability**
The Administrative Manager must receive written notice of a Participant's death whose life insurance benefit coverage was continued due to Total Disability within 12 months of the date of the Participant's death. If written notice is not provided to the Administrative Manager within such 12-month period, the Plan will not be liable for any payment of life insurance benefit for such Participant.

6. **Termination of Continued Coverage During Total Disability**
The Participant's Total Disability will be considered terminated and continued coverage will cease effective as of the date any of the following occur:

(a) The Participant fails to meet the definition of Total Disability;

(b) The Participant fails to furnish written proof of continued Total Disability, as required; or

(c) The Participant fails to submit to a physical examination as may be required by the Board of Trustees or insurance company.

7. **Rights After Termination of Disability**
If the Participant ceases to be Totally Disabled, the Participant will be eligible for a life insurance benefit only if he or she satisfies the requirements set forth in the *Eligibility and Participation* section in effect at that time. If the Participant fails to satisfy such requirements, the Participant will be eligible for an individual policy of insurance under the conversion privilege.

8. **Conversion Privilege**
If your life insurance coverage terminates due to your loss of eligibility under the Plan, you may convert your life insurance to an individual policy at your expense. An application for conversion must be filed within 31 days from the date your life insurance coverage under the Plan is terminated. Please contact the Administrative Manager for details.

C. AD&D Benefits

Accidental death and dismemberment (AD&D) benefits are provided under a policy of group insurance issued to the Board of Trustees. This section summarizes the general provisions of the master policy and individual certificates of insurance issued by the insurance company. In all cases, the master policy or certificate of insurance will govern benefit payments.

1. **Coverage for Participants Only**
   If a Participant loses a limb or an eye, or dies from a bodily Injury, the Plan will pay AD&D benefits up to the principal sum set forth in the *Schedule of Life and AD&D Benefits*, provided:

   (a) The loss or Injury was caused solely by an accident that occurred while the Participant is covered under the Plan;

   (b) The loss or Injury is directly related to the accident and is independent of all other causes; and

   (c) The loss or Injury occurred within 90 days of the accident.

2. **Payment of Benefit**
   The AD&D benefit payment will be made directly to the Participant, if living, otherwise to the Participant's designated beneficiary. See the *Beneficiary Designation* section for beneficiary designation information and requirements.

3. **Loss Defined**
   Loss of a hand or foot means complete severance through or above the wrist or ankle joint, respectively. Loss of an eye means the irrecoverable and complete loss of sight thereof.

D. Life Insurance and AD&D Claim and Appeal Procedures

1. **Administration of Life Insurance and AD&D Claim and Appeal Procedures**
   The Insurer (Union Labor Life Insurance Company or "ULLICO") that provides life insurance and AD&D benefits for Participants under a policy for group insurance issued to the Trustees is the Life Insurance and AD&D Insurance Claims Administrator and fiduciary for life insurance and AD&D benefit claims and appeals. The Insurer's decision on the payment or denial of a claim is final and binding.

2. **How to File a Claim for Life or AD&D Insurance Benefits**
   To file a claim for life insurance or AD&D benefits, a claim form must first be obtained from the Administrative Manager (Auxiant). The claim form must be completed and submitted, with all required documentation, to the Administrative Manager at the address below:

   Auxiant
   Attn: Union Services
   P.O. Box 75008
   Cedar Rapids, IA 52407
   800-475-2232 ext. 1221

3. **When to File a Claim for Life Insurance or AD&D Benefits**
   All claims for life insurance or AD&D benefits should be reported promptly. The deadline for filing a claim for life insurance or AD&D benefits is 90 days after the date of the loss causing the claim. If the claimant is unable to meet the deadline for filing a claim through no fault of his or her own, the claim may still be accepted if the claimant files the claim as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the 90-day deadline.

4. **Additional Information on Life Insurance and AD&D Benefit Claims and Appeals**
   Please refer to the *General Claim and Appeal Procedures* section of this SPD for more information on life insurance and AD&D benefit claims and appeals.

Section X

Other Benefit Payment Provisions

A. General Payment Provisions
B. General Claim and Appeal Procedures
C. Medicare/Medicaid
D. Subrogation and Reimbursement
E. Workers' Compensation

A. General Payment Provisions

1. **Authorization for Direct Payment of Benefits**
   Neither you nor any of your dependents may anticipate, alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber benefits or rights available due to coverage under the Plan (see the *Non-Assignment* section for more information). However, amounts payable to service providers for benefits covered under the Plan may be made directly to such service providers at any time. The Plan may treat any document attempting to assign your (or your dependents') rights or benefits to a service provider as an authorization for direct payment by the Plan to the service provider. The Plan may send payments for the claims to the service provider after approving an authorization for direct payment, but it will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to you or your authorized representative.

2. **Facility of Payment**
   Every Participant receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent, capable and of age until the Plan Administrator receives a written notice, in a form and manner acceptable to the Trustees, that such Participant is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of the Participant's estate has been appointed. However, if the Plan Administrator finds that any person to whom a benefit is payable under the Plan is unable to care for his or her affairs because of any mental or physical incompetency, incapacity or because he or she is a minor, any payment due (unless a prior claim has been made by a duly appointed legal representative of such person's estate) may be paid to the legal spouse, a child, a parent, a sibling, beneficiary or to any person with whom such person is residing, or to any other person or institution deemed by the Trustees to have incurred expense on behalf of such person otherwise entitled to payment.

   In the event a guardian, conservator or other person legally vested with the care of the estate of any Participant receiving or claiming benefits under the Plan will be appointed by a court of competent jurisdiction, payments will be made to such guardian, conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Trustees. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

3. **Rights of Recovery and Recoupment**
   In the event any payment has been made by the Plan with respect to 1) allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, 2) benefits for which payment was not due and payable under the terms of the Plan or 3) when the Covered Person has not cooperated with the Plan or has done something to compromise the Plan's rights or has refused to reimburse the Plan from any recoveries (collectively known as "erroneous payments"), the Board of Trustees will have the right, exercisable in its sole discretion, to recover such erroneous payments plus related amounts (*e.g.*, interest and costs), from any one or more of the following sources:

   (a) Any service provider, insurance company, or other entity to whom such unauthorized payment or erroneous payment was made, thus making the Participant personally liable for such amounts; or

   (b) The Participant or dependent to whom or on whose behalf such erroneous payment was made, including by making deductions from benefits payable to them, or on their behalf to third parties, or causing other adjustments of benefits or offsetting payments which may be payable in the future; or

   (c) The estate or legal representative of the Participant or dependent to whom or on whose behalf such erroneous payment was made.

A. General Payment Provisions

The Plan will be permitted to pursue legal and equitable remedies (*e.g.*, an equitable lien by agreement, constructive trust, offset or setoff) to recover erroneous payments and related amounts.

The Trustees will establish the interest rate to be applied to any erroneous payments.

B. General Claim and Appeal Procedures

The Plan offers various types of benefits (e.g., medical, vision, HRA), with varying legal requirements pertaining to administrative procedures for processing benefit claims and requests for review (i.e., appeals) of denied claims or other adverse benefit determinations. Also, the Plan's benefits are administered by various Claims Administrators, with varying requirements pertaining to filing benefit claims. This section describes the Plan's general claim and appeal procedures that apply to benefits provided under the Plan, unless indicated otherwise in this SPD. Additional details for each type of benefit claim can be found in the *Claim and Appeal Procedures* sections following the sections describing each type of benefit.

1. **Administration of Claim and Appeal Procedures**
   The applicable Claims Administrator processes benefit claims and makes the initial determination on whether claims for benefits are approved or denied. The applicable Claims Administrator also processes appeals; however, the Plan's Board of Trustees makes all final decisions on appeals (except appeals for medical, prescription drug, life insurance and AD&D benefits).

2. **Authorized Representative**
   You may designate an authorized representative to act on your behalf to file a claim for benefits, provide information regarding your claim, or file an appeal of an adverse benefit determination on a claim. Such authorization must be in writing, signed by you, and must include all required information set forth on the applicable Claim Administrator's Authorized Representative Designation Form. Please contact the Claim Administrator to obtain an Authorized Representative Designation Form. You may designate one person at a time to be your authorized representative. You may revoke your authorized representative designation at any time by notifying the Administrative Manager in writing of such revocation. In a Medically Urgent Situation, your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Designation Form. A "Medically Urgent Situation" is a situation where a longer, non-urgent response time could seriously jeopardize the life or health of the Covered Person seeking services or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be managed without the services in question.

   An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make that provider an authorized representative.

3. **Avoiding Conflicts of Interest**
   Claims and appeals for benefits under the Plan will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in determining whether to approve or deny claims and appeals. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a Claims Administrator or medical expert) involved in making benefit determinations will not be made based upon the likelihood that such individual will support the denial of benefits.

4. **How to File a Claim for Benefits**
   Please refer to the *Claim and Appeal Procedures* section applicable to the type of benefit claim you wish to file.

5. **Types of Claims**

   (a) **Urgent Care Claims**
   An urgent care claim is a claim for medical care or treatment with respect to which lack of immediate processing of the claim could seriously jeopardize the life or health of the claimant or subject the claimant to severe pain that cannot be adequately managed without the care or treatment

that is the subject of the claim. Whether a claim is an urgent care claim will be determined by the Claims Administrator, deferring to the judgment of a Physician with knowledge of the claimant's condition.

(b) **Pre-Service Claims**
A pre-service claim is a claim for medical care or treatment with respect to which the Plan requires approval of the benefit in advance of obtaining medical care (e.g., preauthorization).

(c) **Concurrent Care Claims**
A concurrent care claim is any request by a claimant to extend the duration or number of medical treatments previously approved and subsequently reduced or terminated.

(d) **Post-Service Claims**
A post-service claim is any request by a claimant for payment or reimbursement of services already provided to the claimant. Most claims submitted to the Plan are post-service claims.

(e) **Short Term Disability Benefit Claims**
A short term disability benefit claim is a request for short term disability benefits from the Plan.

(f) **Life Insurance or Accidental Death and Dismemberment (AD&D) Benefit Claims**
A life insurance or AD&D benefit claim is a request for life insurance benefits or AD&D insurance benefits from the Plan's insurance carrier.

6. **Time Limits for Decisions on Claims**

(a) **Urgent Care Claims**
Generally, the applicable Claims Administrator will inform you of its decision on your urgent care claim as soon as possible, but not later than 72 hours after the claim is filed. If the applicable Claims Administrator needs additional information from you to render a decision on your claim, you will be notified of the specific information needed within 24 hours and you will have at least 48 hours to provide the information to the Claims Administrator. After you provide the required information, the applicable Claims Administrator will render a decision on your claim and will inform you of that decision no later than 48 hours after the additional information was received.

(b) **Pre-Service Claims**
Generally, the applicable Claims Administrator will inform you of its decision on your pre-service claim within 15 days of the date the claim is filed. However, the applicable Claims Administrator may extend the initial 15-day claim determination period by up to 15 days, provided circumstances beyond the Plan's control require additional time to make a decision on your claim. In such case, the applicable Claims Administrator will provide notice of the extension to you prior to the expiration of the initial 15-day determination period. The notice of extension will explain the circumstances that require an extension (e.g., unresolved issues; additional information needed), and the date by which the applicable Claims Administrator expects to render a decision on your claim.

If the applicable Claims Administrator needs additional information from you to render a decision on your claim, you will be notified of the specific information needed within the 15-day (if extended, 30-day) determination period described above, and you will have at least 45 days to provide such information to the applicable Claims Administrator. The 15-day (if extended, 30-day) determination period described above will be tolled while the applicable Claims Administrator waits for additional required information from you. After you provide the required information to the applicable Claims Administrator or, if earlier, the time period for providing the required information has expired, the

applicable Claims Administrator will render a decision on your claim and will issue a written notice to you of its decision.

(c) **Concurrent Care Claims**

If your concurrent care claim involves urgent care and was received by the applicable Claims Administrator at least 24 hours before expiration of the previously approved time period for treatment or number of treatments, the applicable Claims Administrator will inform you of its decision on your concurrent care claim within 24 hours after receiving the claim. If your concurrent care claim does not involve urgent care or is received by the applicable Claims Administrator less than 24 hours before expiration of the previously approved time period for treatment or number of treatments, the applicable Claims Administrator will respond according to the type of claim involved (i.e., pre-service or post-service).

(d) **Post-Service Claims**

Generally, the applicable Claims Administrator will inform you of its decision on your claim within 30 days of the date the claim is filed. However, the applicable Claims Administrator may extend the initial 30-day claim determination period by up to 15 days, provided circumstances beyond the Plan's control require additional time to make a decision on your claim. In such case, the applicable Claims Administrator will provide notice of the extension to you prior to the expiration of the initial 30-day determination period. The notice of extension will explain the circumstances that require an extension (e.g., unresolved issues; additional information needed), and the date by which the applicable Claims Administrator expects to render a decision on your claim.

If the applicable Claims Administrator needs additional information from you to render a decision on your claim, you will be notified of the specific information needed within the 30-day (if extended, 45-day) determination period described above, and you will have at least 45 days to provide such information to the applicable Claims Administrator. The 30-day (if extended, 45-day) determination period described above will be tolled while the applicable Claims Administrator waits for additional required information from you. After you provide the required information to the applicable Claims Administrator or, if earlier, the time period for providing the required information has expired, the applicable Claims Administrator will render a decision on your claim and will issue a written notice to you of its decision.

(e) **Short Term Disability Benefit Claims**

Generally, the applicable Claims Administrator will inform you of its decision on your claim within 45 days of the date the claim is filed. However, the applicable Claims Administrator may extend the initial 45-day claim determination period by up to 30 days, provided circumstances beyond the Plan's control require additional time to make a decision on your claim. In such case, the applicable Claims Administrator will provide notice of the extension to you prior to the expiration of the initial 30-day determination period. The notice of extension will explain the circumstances that require an extension (e.g., unresolved issues; additional information needed), and the date by which the applicable Claims Administrator expects to render a decision on your claim, the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the issues.

If circumstances beyond the Plan's control continue to require additional time to make a decision on your claim, the applicable Claims Administrator may extend the determination period for an additional 30 days. In such case, the applicable Claims Administrator will provide notice of the second 30-day extension to you prior to the expiration of the initial 30-day extension period. The notice will explain the circumstances that require an extension (e.g., unresolved issues; additional

information needed), the date by which the applicable Claims Administrator expects to render a decision on your claim, the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, and the additional information needed to resolve the issues.

If the applicable Claims Administrator needs additional information from you to render a decision on your claim, you will be notified of the specific information needed within the 45-day (if extended once, 75 day; if extended twice, 105-day) determination period described above, and you will have at least 45 days to provide such information to the applicable Claims Administrator. The 45-day (if extended once, 75 day; if extended twice, 105-day) determination period described above will be tolled while the applicable Claims Administrator waits for additional required information from you. After you provide the required information to the applicable Claims Administrator or, if earlier, the time period for providing the required information has expired, the applicable Claims Administrator will render a decision on your claim and will issue a written notice to you of its decision.

(f) **Life Insurance or Accidental Death and Dismemberment (AD&D) Insurance Claims**
Generally, the Insurer will determine whether to approve or deny the claim within 90 days of the date the claim is filed. However, the Insurer may extend the initial 90-day determination period by up to 90 days, provided circumstances beyond the Insurer's control require additional time to make a decision on the claim. In such case, the Insurer will provide written notice of the extension to the claimant prior to the expiration of the initial 90-day determination period. The notice of extension will explain the circumstances that require an extension (e.g., unresolved issues; additional information needed), and the date by which the Insurer expects to render a decision on whether to approve or deny the claim.

If the Insurer needs additional information from the claimant to render a decision on the claim, the claimant will be notified of the specific information needed within the 90-day (if extended, 180-day) determination period described above, and the claimant will have at least 45 days to provide such information to the Insurer. The 90-day (if extended, 180-day) determination period described above will be tolled while the Insurer waits for additional required information from the claimant. After the claimant provides the required information to the Insurer or, if earlier, the time period for providing the required information has expired, the Insurer will render a decision on the claim and will issue a written notice to the claimant of its decision.

7. **Adverse Benefit Determinations**
An adverse benefit determination is any of the following:

(a) A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including an individual's eligibility for coverage under the Plan, or a determination that a benefit is not a covered benefit;

(b) A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigative or not medically necessary or appropriate; or

(c) A rescission of coverage, regardless of whether there is an adverse effect on any particular benefit provided under the Plan at that time.

B. General Claim and Appeal Procedures

8. **Notice of Denial or Adverse Benefit Determination on a Claim**

(a) **All Claim Denial or Adverse Benefit Determination Notices Except for Life Insurance and AD&D Benefits**
If your claim for benefits is partially or wholly denied, you will receive a written notice from the applicable Claims Administrator that includes the following information below, as applicable. For urgent care claims, the applicable Claims Administrator may first provide such notice orally.

(i) Information sufficient to identify the claim involved;

(ii) Specific reason(s) for the adverse benefit determination;

(iii) Specific reference to the pertinent Plan provision(s) on which the adverse benefit determination is based;

(iv) A description of any additional material or information necessary to process your claim, and an explanation of why such material or information is necessary;

(v) A description of the Plan's internal review (i.e., appeal) procedures, and the time limits applicable to such procedures;

(vi) A statement of your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on appeal;

(vii) If the adverse benefit determination was based on a determination of medical necessity, experimental nature of treatment or similar matter, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that you may request a copy of such explanation, free of charge;

(viii) If an internal rule, guideline, protocol or other similar criterion was relied upon while making a decision on your claim, a statement that you may request a copy of such internal rule, guideline, protocol or other similar criterion, free of charge;

(ix) A statement of your right to request the diagnosis and treatment codes for the claim and their corresponding meanings, free of charge;

(x) If the adverse benefit determination was based on medical judgment, a statement of your right to request an external review with an independent review organization following denial on appeal; and

(xi) A description of how to initiate the expedited external review process for an adverse benefit determination that involves a medical condition for which the timeframe for completion of the internal appeal would jeopardize your life or health or would jeopardize your ability to regain maximum function.

(b) **Short Term Disability Claim Denial or Adverse Benefit Determination Notices**
If your claim for short term disability benefits is partially or wholly denied, you will receive a written notice from the applicable Claims Administrator that includes the information set forth in in subsection (a) above, and the information listed below, as applicable.

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views of health care professionals treating you and vocational professionals who evaluated you;

(B) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim, without regard to whether the Administrative Manager relied on the advice to make the benefit determination; and

(C) A disability determination issued to you by the Social Security Administration;

(ii) Copies of any internal rule, guideline, protocol or similar criterion relied on while making a decision on your claim, or a statement that no such rule, guideline, protocol or similar criterion was considered;

(iii) A statement that you are entitled to receive reasonable access to and copies of all documents, records and other information relevant (as described in the *Relevant Documents, Records and Other Information* section) to your claim, upon request and free of charge;

(iv) If the notice is being sent to an address in a county in which 10% or more of the population is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor, the Plan must:

(A) Provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(B) Provide, upon request, a notice in any applicable non-English language; and

(C) Include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the Plan's language services.

(c) **Life Insurance or AD&D Claim Denial or Adverse Benefit Determination Notices**
If the Insurer partially or wholly denies a claim for life insurance or AD&D benefits, the Insurer will provide written or electronic notification to the claimant of the adverse benefit determination that includes the information listed below, as applicable.

(i) Specific reason(s) for the adverse benefit determination;

(ii) Specific reference to pertinent policy provisions on which the adverse benefit determination is based;

(iii) Description of any additional material or information necessary to process the claim, and an explanation of why such material or information is necessary;

(iv) Description of the Insurer's review procedures and the time limits applicable to such procedures; and

(v) Statement of the claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review.

B. General Claim and Appeal Procedures

9. **Request for Review of a Claim Denial or Adverse Benefit Determination**
If your claim was partially or wholly denied, you have the right to appeal to the Trustees, the Insurer, or the delegated Claims Administrator, as applicable (for purposes of this section, the "Claims Administrator"), for a review of your denied claim. For HRA, medical or prescription drug, dental, vision, or short-term disability claims, you must provide written notice of your request (oral notice may be provided for urgent care claims) for a review to the applicable Claims Administrator within 180 days from the date the written notice of your denied claim was issued to you. For life insurance and AD&D benefit claims, the claimant must provide written notice of the request for an appeal to the Insurer within 60 days from the date the written notice of an adverse benefit determination was issued to the claimant. A claimant who receives an adverse benefit determination will be entitled to a full and fair review of that determination.

(a) **Expedited Review for Urgent Care Claims**
You must provide oral or written notice of your request for an expedited review to the applicable Claims Administrator, which should include all information regarding the claim, as well as the specific reason(s) you feel the initial decision on your claim was improper. Copies of any documents relevant to the claim will be provided at no cost, upon request. All necessary information will be transmitted by phone, facsimile, e-mail or another expeditious method.

(b) **Standard Review for Non-Urgent Care Claims**
You must provide written notice of your request for a review to the applicable Claims Administrator, which should include all information regarding the claim, as well as the specific reason(s) you feel the initial decision on your claim was improper. Copies of any documents relevant to the claim will be provided at no cost, upon request.

10. **Full and Fair Review of Appeals**
The Claims Administrator will review a denied claim or adverse benefit determination in accordance with the terms and conditions of the Plan.

(a) The Claims Administrator will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination.

(b) You have the right to access or receive copies of all documents, records and other information relevant (as described in the *Relevant Documents, Records and Other Information* section to your claim.

(c) You have the right to request identification of medical or vocational experts, if any, whose advice was obtained on behalf of the Plan in connection with your denied claim, without regard to whether the advice was relied upon in making the determination on your claim.

(d) If the decision requires medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator will consult an appropriate health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is not the same health professional or subordinate to any health professional who reviewed your claim initially.

(e) For HRA, medical or prescription drug, vision, and short-term disability claim appeals, the Claims Administrator will provide to you, free of charge, any new or additional evidence considered, relied

upon, or generated by or at the direction of the applicable Claims Administrator, the Board of Trustees or its authorized Committee (if applicable) in connection with your claim as soon as possible and sufficiently in advance of the date the Claims Administrator is expected to render a final decision on your claim, to give you a reasonable opportunity to respond.

(f) For HRA, medical or prescription drug, vision and short-term disability claim appeals, the applicable Claims Administrator will provide to you, free of charge, any new or additional rationale for denying your claim as soon as possible and sufficiently in advance of the date the Claims Administrator is expected to render a final decision on your claim, to give you a reasonable opportunity to respond.

11. **Relevant Documents, Records and Other Information**
A document, record or other information is relevant if:

(a) It was relied upon by the Claims Administrator in making the decision;

(b) It was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon);

(c) It demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making; or

(d) It constitutes a statement of Plan policy regarding the denied treatment or service.

12. **Time Limits for Decisions on Appeals**

(a) **Urgent Care Claims**
The applicable Claims Administrator will inform you of the decision on your urgent care claim appeal as soon as possible, but not later than 72 hours after the applicable Claims Administrator received your appeal.

(b) **Pre-Service Claims**
The applicable Claims Administrator will inform you of the decision on your pre-service claim appeal within 30 days of the date the applicable Claims Administrator received your appeal.

(c) **Concurrent Care Claims**
If your concurrent care claim appeal involves urgent care, the applicable Claims Administrator will inform you of its decision on your concurrent claims appeal as soon as possible, but not later than 72 hours after the applicable Claims Administrator received your appeal. If your concurrent care claim appeal does not involve urgent care, the applicable Claims Administrator will respond according to the type of claim involved (i.e., pre-service or post-service).

(d) **Post-Service Claims**
For medical and prescription drug benefit post-service claims, the Claims Administrator will render a decision on all post-service claim appeals within 60 days.

For post-service claims for benefits for which the Board of Trustees decides appeals, the Board of Trustees or its authorized Committee (if applicable) will meet quarterly to review and render decisions on all post-service claim appeals received since the previous quarterly meeting; however, any appeal received by the applicable Claims Administrator within the 30-day period preceding a meeting will be reviewed at the next following quarterly meeting. If special circumstances require an extension of time to render a decision on your appeal, the decision will be rendered no later than the third quarterly

meeting following the date the applicable Claims Administrator received your appeal. The applicable Claims Administrator will provide written notice of the extension to you, describing the special circumstances and date by which the decision will be made, prior to the commencement of any extension. The applicable Claims Administrator will notify you in writing of the Trustees' decision on your appeal within five days of the date the decision is made.

(e) **Short Term Disability Benefit Claims**
The Board of Trustees or its authorized Committee (if applicable) will meet quarterly to review and render decisions on all short term disability benefit claim appeals received since the previous quarterly meeting; however, any appeal received by the applicable Claims Administrator within the 30-day period preceding a meeting will be reviewed at the next following quarterly meeting. If special circumstances require an extension of time to render a decision on your appeal, the decision will be rendered no later than the third quarterly meeting following the date the applicable Claims Administrator received your appeal. The applicable Claims Administrator will provide written notice of the extension to you, describing the special circumstances and date by which the decision will be made, prior to the commencement of any extension. The applicable Claims Administrator will notify you in writing of the Trustees' decision on your appeal within five days of the date the decision is made.

(f) **Life Insurance and AD&D Benefit Claims**
The Insurer will provide the claimant with written or electronic notification of a benefit determination on review. The Insurer will provide the notice within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the Insurer (unless there is a review by a committee). The Insurer may determine that an extension of time for processing the claim is required. If an extension is required, the Insurer will provide written notice of the extension to the claimant before the end of the initial 60-day period. The notice must indicate the special circumstances requiring an extension of time and the date by which the Insurer expects to render the determination on review. The extension of the determination on review will not exceed a period of 60 days from the end of the initial period.

13. **Notice of Denial or Adverse Benefit Determination on an Appeal**

(a) **All Appeal Denial or Adverse Benefit Determination Notices Except for Life Insurance and AD&D Benefits**
If your appeal for a claim for benefits other than life insurance or AD&D benefits is partially or wholly denied, you will receive a written notice from the applicable Claims Administrator that includes information listed below, as applicable. For appeals of urgent care claims, the applicable Claims Administrator may first provide such notice orally.

(i) Information sufficient to identify the claim involved;

(ii) Specific reason(s) for the adverse benefit determination;

(iii) Specific reference to the pertinent Plan provision(s) on which the adverse benefit determination is based;

(iv) A statement of your right to request reasonable access to and copies of all documents, records and other information relevant (as described in the *Relevant Documents, Records and Other Information* section) to your claim, free of charge;

(v) A statement of your right to bring a civil action under ERISA section 502(a);

(vi) If the adverse benefit determination was based on a determination of medical necessity, experimental nature of treatment or similar matter, either an explanation of the scientific

or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that you may request a copy of such explanation, free of charge;

(vii) If an internal rule, guideline, protocol or other similar criterion was relied upon while making a decision on your claim, a statement that you may request a copy of such internal rule, guideline, protocol or other similar criterion, free of charge;

(viii) A statement of your right to request the diagnosis and treatment codes for the claim and their corresponding meanings, free of charge;

(ix) A description of how to initiate the expedited external review process for an adverse benefit determination that involves a medical condition for which the timeframe for completion of the internal appeal would jeopardize your life or health or would jeopardize your ability to regain maximum function;

(x) If the adverse benefit determination was based on medical judgment or is otherwise eligible for external review, a statement of your right to request an external review with an independent review organization; and

(xi) A description of how to initiate the expedited external review process for an adverse benefit determination that involves a medical condition for which the timeframe for completion of the internal appeal would jeopardize your life or health or would jeopardize your ability to regain maximum function.

(b) **Short Term Disability Appeal Denial or Adverse Benefit Determination Notices**
If your appeal for short term disability benefits is partially or wholly denied, you will receive a written notice from the applicable Claims Administrator that includes the information set forth in in subsection (a) above, and the information listed below, as applicable.

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following:

(A) The views of health care professionals treating you and vocational professionals who evaluated you;

(B) The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim, without regard to whether the Administrative Manager relied on the advice to make the benefit determination; and

(C) A disability determination issued to you by the Social Security Administration;

(ii) Copies of any internal rule, guideline, protocol or similar criterion relied on while making a decision on your claim, or a statement that no such rule, guideline, protocol or similar criterion was considered;

(iii) If the notice is being sent to an address in a county in which 10% or more of the population is literate only in the same non-English language, as determined in guidance published by the Secretary of the Department of Labor, the Plan must:

(A) Provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;

(B) Provide, upon request, a notice in any applicable non-English language; and

(C) Include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the Plan's language services.

(c) Life Insurance and AD&D Appeal Denial or Adverse Benefit Determination Notices
If an appeal for life insurance or AD&D is partially or wholly denied, the claimant will receive a written notice from the Insurer that includes information listed below, as applicable.

(i) Specific reason(s) for the adverse benefit determination;

(ii) Specific reference to the pertinent policy provision(s) on which the adverse benefit determination is based;

(iii) A statement of the claimant's right to request reasonable access to and copies of all documents, records and other information relevant (as described in the *Relevant Documents, Records and Other Information* section) to the claim, free of charge; and

(iv) A statement of the claimant's right to bring a civil action under ERISA section 502(a).

14. **External Review of a Denied Claim**
You have the right to request an external review of a denied claim for medical, prescription and HRA benefits if the denial involved medical judgment (*e.g.,* the treatment service or supply was not medically necessary or was experimental/investigational in nature) or effective January 1, 2022, was for protected services under the No Surprises Act, provided you have exhausted the Plan's internal claim and appeal procedures. If you want to have a denied claim reviewed by an independent review organization ("IRO"), you must send a written request for an external review of the claim to the applicable Claims Administrator no later than four months after the date the written notice of the Reviewer's adverse benefit determination on your appeal was issued to you. You may submit additional materials for consideration during the external review, including a written explanation of and comments on the issues.

15. **Expedited External Review of a Denied Claim**
You have the right to request an expedited external review of a denied urgent care claim, if the denial involved medical judgment and involves a medical condition for which the timeframe for completion of either an expedited internal appeal or a standard external review would seriously jeopardize your life or health, or would jeopardize the your ability to regain maximum function, and you have filed a request for an expedited internal appeal. You may also have the right to request an expedited external review of a final adverse determination that concerns an Admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not been discharged from a facility. Please refer to the *Medical and Prescription Drug Benefits* section for more details on expedited external reviews.

16. **Legal Action**
No lawsuit or other legal action against the Plan or its Trustees may be filed before you exhaust the Plan's claim and appeal procedures, or after one year from the date written notice of the decision on your appeal was issued to you. If this time limitation is less than that required by law, the limitation will be extended to agree with the minimum period permitted by law.

C. Medicare/Medicaid

1. **Integration of Benefits with Medicare**

If you are eligible for Medicare and receive Medicare-covered services for which benefits are payable under the Plan, then the applicable Claims Administrator will determine if the Plan is primary or secondary to coverage provided by Medicare Parts A and B, based on your employment status on the date the covered service is rendered. Primary means that benefits payable under the Plan will be determined and paid without regard to Medicare Parts A and B.

(a) **Which Plan Pays First**

(i) The Plan will always be primary to Medicare Parts A and B if you:

(A) Are an eligible Employee age 65 or older who has current employment status with a Contributing Employer, or are the Spouse age 65 or older of an eligible Employee who has current employment status with a Contributing Employer; or

(B) Are under age 65 and entitled to Medicare due to Social Security disability, and are covered due to a Participant's current employment status; or

(C) Are entitled to benefits under Medicare because of end stage renal disease ("ESRD") (kidney disease) during the "coordination period" prescribed by Medicare regulations (currently the first 30 months).

(ii) The Plan will be secondary to Medicare Parts A and B if you:

(A) Have been entitled to benefits under Medicare because of end stage renal disease ("ESRD") (kidney disease) for longer than the "coordination period" prescribed by Medicare regulations (currently the first 30 months).

(B) Are over age 65 and do not have current employment status with a Contributing Employer or are not the dependent of a Participant with current employment status with a Contributing Employer (*e.g.*, you are a retiree or dependent of a retiree, or a COBRA beneficiary who is not in the ESRD coordination period).

For more information, see Medicare Publication No. 02179, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can find it at www.medicare.gov/publications.

(b) **Enrollment in Medicare Parts A and B If Plan Pays Primary**

Even if you keep working after you turn age 65, you should sign up for Medicare Part A. Part A may still help pay some of the costs not covered by the Plan, and it doesn't cost you anything. Call the Social Security Administration at 1-800-772-1213 to sign up.

You may want to wait to sign up for Medicare Part B if you are still working and covered by the Plan. You would have to pay the monthly Medicare Part B premium, and the Medicare Part B benefits may be of limited value to you as long as the Plan is the primary payer of your medical bills. Once you stop working, you can enroll in Part B without paying the higher premium penalty usually associated with late enrollment. For more information, see Medicare Publication No. 11219, "Understanding Medicare Enrollment Periods." You can find it at www.medicare.gov/publications.

(c) **Enrollment in Medicare Parts A and B If Plan Pays Secondary**
You should enroll in Medicare Parts A and B if the Plan pays secondary to Medicare. If the Plan pays secondary to Medicare, and you do not enroll for coverage under Medicare Part A and Part B or do not make a claim for Medicare Parts A and B benefits, the applicable Claims Administrator will calculate benefits under the Plan as if you were enrolled in Medicare Parts A and B and full claim for Medicare Parts A and B benefits has been made.

2. **Effect of Medicaid Coverage**

(a) **Assignment of Rights**
The Plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits pursuant to Title XIX of the Social Security Act (Medicaid).

(b) **Enrollment Without Regard to Medicaid**
Your receipt or eligibility for benefits under Medicaid will not affect your enrollment as a Participant or Covered Person in the Plan, nor will it affect the determination of your benefits.

(c) **Acquisition by States of Rights of Third Parties**
If payment has been made by Medicaid and the Plan has a legal obligation to provide benefits for those services, the applicable Claims Administrator will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

(d) **Medicaid Reimbursement**
When a PPO or service provider submits a claim to a state Medicaid program for a covered service and the Plan reimburses the state Medicaid program for the service, the Plan's total payment for the service will be limited to the amount paid to the state Medicaid program. No additional payments will be made to the provider or to you.

D. Subrogation and Reimbursement

This *Subrogation and Reimbursement* section applies to all benefits offered by the Plan, except life insurance and accidental death and dismemberment insurance. Additional terms for subrogation and reimbursement for medical and prescription drug benefits are included in the *Medical and Prescription Drug Benefits* section.

1. **Subrogation and Reimbursement Definitions**
   These terms will have the following meanings in this *Subrogation and Reimbursement* section:

   (a) "Individual" means the Covered Person or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Covered Person.

   (b) "Source" includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured motorist coverage, underinsured motorist coverage, home owners insurance coverage, injury compensation program and any employer of the Individual under the provisions of a workers' compensation or occupational disease law.

2. **Plan's Rights to Subrogation and Reimbursement**

   (a) **Statement of Rights**
   The Plan will be subrogated to all rights of recovery of an Individual to the extent of any amounts the Plan has paid or may become obligated to pay on account of any claim against a Source in connection with the Injury, Illness, disease, disability, accident or condition to which the claim relates. The Plan will also be entitled, to the extent of payments made or payments due to be made by the Plan on account of the claim, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual.

   (b) **Priority Rights**
   Such subrogation and reimbursement rights will apply on a priority, first-dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole, and will apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. The Individual will be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Injury, Illness, disease, disability, accident or condition, and the Plan's recovery will not be reduced by such legal fees or expenses unless the Plan, in its sole discretion, has agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses. The Plan specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment.

   (c) **Automatic Lien/Constructive Trust**
   Once the Plan makes or is obligated to make payments on behalf of an Individual on account of the claim, the Plan is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

(d) **Excess Benefits**
If at the time of the Injury, Illness, disease, disability, accident or condition there is available, or potentially available proceeds from any Source, the benefits under this Plan will apply only as an excess over such proceeds.

(e) **Wrongful Death**
In the event that the Individual dies as a result of his or her Injury, Illness, disease, disability, accident or condition and a wrongful death or survivor claim is asserted against any Source, the Plan's subrogation and reimbursement rights will still apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as award to the Individual's estate or to surviving Covered Persons, representatives, guardians, beneficiaries, trustees, estate representatives, heirs, executors or administrators of special needs trusts.

3. **Action Required of Individual**

(a) **Cooperation and Assistance**
If requested in writing by the Plan, the Individual will take such action as may be necessary or appropriate to recover payments made or payments due to be made by the Plan from any Source and will hold that portion of the total recovery from any Source that is due for payments made or payments due to be made in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery thereof. The Individual will not do anything to impair, release, discharge or prejudice the rights referred to in this section, and will not dissipate any amount of recovery to which the Plan claims an equitable lien by agreement. The Individual will assist and cooperate with representatives designated by the Plan to recover payments made by the Plan and will do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

(b) **Execution of Agreement**
The Plan may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Plan, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s) at the Plan's request or if the Agreement is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments applicable to the Individual. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that Individual's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent or deceased adult) must execute the Agreement upon request of the Plan. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the Individual agrees that out of any Source the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Plan's benefit and that the Plan will have an equitable lien by agreement that will be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights will apply regardless of whether the Individual executes an Agreement.

(c) **Plan as Co-Payee**
The Individual agrees to include the Plan's name as a co-payee on any and all settlement drafts.

(d) **Individual's Minor Status**
In the event the Individual is a minor as the term is defined by applicable law, the minor's parents or court-appointed guardian must cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned. If the minor Individual's parents or court-appointed guardian fails to take such action, the Plan will have no obligation to advance payment of benefits on behalf of the minor Individual. Any court costs or legal fees associated with obtaining such approval will be paid by the minor Individual's parents or court-appointed guardian.

4. **Enforcement**.

(a) **Methods of Recovery**
The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including, but not limited to, the initiation of a recognized cause of action under ERISA section 502(a)(3) (including injunctive action to ensure the claim amounts that the Plan has advanced are preserved and not disbursed or dissipated) or applicable federal or state law and the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

(b) **No Tracing Required**
The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

(c) **Plan's Right to Offset**
Further, in the event an Individual receives monies as the result of an Injury, Illness, disease, disability, accident or condition and the Plan is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such Injury, Illness, disease, disability, accident or condition, the Plan will have the right to reduce future payments due to such Individual or the Participant of whom such Individual is a dependent or any other dependent of such Participant by the amount of benefits paid by the Plan. The right of offset will not, however, limit the rights of the Plan to recover such monies in any other manner described in this section.

5. **Language Interpretation**
The Board of Trustees retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

6. **Severability**
In the event that any provision in this *Subrogation and Reimbursement* section is considered invalid or illegal for any reason, said invalidity or illegality will not affect the remaining provisions of this *Subrogation and Reimbursement* section, the remaining sections of this SPD or the Plan. This *Subrogation and Reimbursement* section will be fully severable. The Plan will be construed and enforced as if such invalid or illegal sections had never been inserted in the Summary Plan Description or the Plan.

E. Workers' Compensation

If you have received benefits under the Plan for an Injury or condition that is the subject or basis of a workers' compensation claim (whether litigated or not), the Plan is entitled to reimbursement to the extent of benefits paid under the Plan from your employer, your employer's workers' compensation carrier, or you in the event that your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, the Plan is entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. The Plan will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

The Plan utilizes industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. The Plan reserves the right to seek reimbursement of any such claim or to waive reimbursement of any claim, in its discretion. Additional terms related to workers' compensation are included in the *Medical and Prescription Drug Benefits* section.

Section XI

Glossary

Glossary

The following definitions apply to the Plan in general. To the extent that a different definition of the same term appears in this SPD, that definition will apply within that section.

1. **ACCIDENTAL INJURY**
   A condition which is the result of bodily Injury caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences. This incident must be a sufficient departure from the claimant's normal and ordinary lifestyle or routine. The condition must be an instantaneous one, rather than one that continues, progresses or develops.

2. **ADMINISTRATIVE MANAGER**
   The person or firm employed by the Board of Trustees to provide administrative services to the Plan in connection with the operation of the Plan and any other functions, including the collection of contributions, maintenance of eligibility, recordkeeping and carrying out policy decisions made by the Board of Trustees. The Administrative Manager is identified in the *Your Plan Identification at a Glance* section of this SPD.

3. **ADMISSION**
   Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

4. **ADVERSE BENEFIT DETERMINATION**
   Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for coverage under the Plan, and including, with respect to group health plan benefits, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate; and any rescission of disability coverage with respect to a Participant (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term “rescission” means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

5. **BOARD OF TRUSTEES or TRUSTEES**
   The Plan's Board of Trustees is comprised of the Trustees appointed pursuant to the Plan's Trust Agreement, together with their successors. The Board of Trustees will be the Plan Administrator of the Plan as that term is used in ERISA.

6. **CLAIM**
   Any request for a Plan benefit made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims.

7. **CLAIMS ADMINISTRATOR**
   The person or firm employed by the Board of Trustees to provide benefit claims administration services for each benefit offered by the Plan. There may be a separate claims administrator for each benefit.

8. **COBRA**
   Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

9. **COVERED PERSON**
   Any Employee or dependent of an Employee meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

10. **DEDUCTIBLE**
    A specified dollar amount that Participants must pay for covered services during a Plan Year before any other covered services are considered for payment by the Plan. Separate Deductibles apply for various benefits provided under the Plan.

11. **EMPLOYEE**
    The term "Employee" includes:

    (a) **Bargaining Unit Employee** - An active employee represented by the I.B.E.W. Local 405 and working for a Contributing Employer, as defined herein, and with respect to whose employment a Contributing Employer is required to make contributions to the Trust Fund on that employee's behalf, pursuant to a collective bargaining agreement.

    (b) **Non-Bargaining Unit Employee or NBU Employee** - An active employee performing work not covered by a collective bargaining agreement with an I.B.E.W. local union, on a full-time basis ("full-time" is defined by the Contributing Employer in a participation agreement), for a Contributing Employer who is required to make contributions to the Trust Fund on that employee's behalf pursuant to a participation agreement.

    An Employee must receive a W-2 form from his or her Contributing Employer.

12. **EMPLOYER OR CONTRIBUTING EMPLOYER**
    Any association or individual employer that has a collective bargaining agreement in effect with the I.B.E.W. Local 405 or a participation agreement in effect with the Trustees, and is thereby required to make contributions to the Plan on behalf of its Employees. An employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees, agrees to be bound by the Plan's Trust Agreement, enters into a participation agreement or other written agreement with the Trustees and is thereby required to make contributions to this Plan on behalf of its Employees, such as I.B.E.W. Local 405 and Cedar Rapids Electrical Apprenticeship Training and Educational Trust, are also included in this definition.

13. **ERISA**
    The Employee Retirement Income Security Act of 1974, as amended.

14. **ILLNESS**
    A bodily disorder, disease, or mental health condition of a Covered Person, including Pregnancy. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously that are due to the same or related causes will be considered one Illness.

15. **INJURY**
    Accidental bodily damage, including related conditions and recurrent symptoms, that requires treatment by a Physician and is independent of Illness. All injuries to one person from one accident will be considered one Injury.

16. **LIFETIME**

The term "Lifetime," which is used in connection with benefit maximums and limitations, means the period during which an individual is covered under the Plan, whether or not coverage is continuous. Under no circumstances does "Lifetime" mean the duration of the Covered Person's life..

17. **MEDICARE**
The 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 Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

18. **PARTICIPANT**
Any Employee meeting the eligibility requirements for coverage as set forth in the *Eligibility and Participation* section of this SPD who is properly enrolled in the Plan.

19. **PLAN ADMINISTRATOR OR PLAN SPONSOR**
The Board of Trustees is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and Section 3(16)(A) of ERISA. The Board of Trustees is also the Plan Sponsor within the meaning of Section 3(16)(B) of ERISA.

20. **PLAN YEAR**
A 12-month period commencing on January 1 and ending on December 31 of the same given year.

21. **PREGNANCY**
The physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

22. **TOTAL DISABILITY (TOTALLY DISABLED)**
The complete inability, as a result of Injury or Illness that did not arise from work for wage or profit, to perform any and every duty of the Employee's occupation or of a similar occupation for which the Employee is reasonably capable, as determined by the Employee's education and training.

23. **TRUST AGREEMENT**
The Cedar Rapids Electrical Workers Local #405 Health and Welfare Fund Substituted and Amended Agreement and Declaration of Trust between I.B.E.W. Local 405, the Contributing Employers and the Cedar Rapids/Iowa City, Iowa Chapter, National Electrical Contractors Association, Inc. maintaining the Trust, amended and restated effective May 7, 2013, as amended from time to time.

24. **TRUST FUND**
The assets of the Plan held in trust by the Board of Trustees, pursuant to the Trust Agreement.

25. **USUAL, CUSTOMARY AND REASONABLE CHARGE**
This is determined by uniform reference standards as adopted by the Board of Trustees or its delegee.

26. **YOU, YOUR**
The Employee, Participant and family members eligible for coverage under the Plan.

Appendix A – Temporary Provisions Related to COVID-19 Pandemic

The provisions of this Appendix A apply only during the effective dates described herein.

1. The Plan will reimburse Participants for the cost of any Employer-required COVID-19 tests received from April 1, 2021 through August 31, 2021, subject to the following conditions:

   (a) The amount reimbursed must be supported by a COVID-19 testing vendor-provided receipt; and

   (b) The maximum amount that the Plan will reimburse is $130 per test.

   No reimbursement will be provided for COVID-19 tests that are covered under the Plan as required pursuant to Section 6001 of the Families First Coronavirus Response Act (FFCRA), as amended. The reimbursement will not be made through your HRA. All requests for reimbursement must be received by the Plan Administrative Manager within one year of the date the COVID-19 test was administered.

2. The Plan will cover FDA-approved, cleared or authorized over-the-counter ("OTC") COVID-19 tests purchased on or after January 15, 2022 and during the public health emergency declared by the Department of Health and Human Services, subject to the following conditions:

   (a) Covered OTC COVID-19 tests are limited to the tests for when specimens are self-collected and are read at home by the test-taker (not dropped off at or mailed to a laboratory for processing).

   (b) This benefit will be limited to eight OTC COVID-19 tests per Covered Person per month. Some test kits are sold with multiple tests in a single package; the limit number is based on individual tests.

   (c) Covered Persons will be able to obtain tests in-person at most CVS Caremark in-network pharmacies, as well as order them online through select national in-network retail pharmacy chains without upfront payment. OTC COVID-19 tests purchased in-person at in-network pharmacies must be purchased from the pharmacy counter to be covered with no upfront costs.

   (d) Covered Persons who purchase OTC COVID-19 tests from the regular checkouts of in-network pharmacies, from out-of-network pharmacies or from non-pharmacy retailers are eligible for reimbursement. The Covered Person's reimbursement may be limited to $12 per test (or $24 for a box of two tests). If a Covered Person pays out-of-pocket for OTC COVID-19 tests, the Covered Person will need to submit a claim form to CVS Caremark. Instructions to submit a claim to CVS Caremark for reimbursement are available in the FAQs section at https://www.wellmark.com/about/newsroom/coronavirus-covid-19.

   (e) OTC COVID-19 tests covered under this benefit must be for personal use by a Covered Person. Tests used for employment purposes or for purposes of resale are not covered or reimbursable under this benefit.

   (f) You cannot use your HRAs to purchase OTC COVID-19 tests that will be covered or reimbursed under this benefit. However, you can use your HRA to purchase tests that you or your covered family members need beyond the eight monthly covered or reimbursable tests.