

Notice

The official Plan Document that describes the benefits for which you are eligible under your group health plan is available, in print, in the department of your employer or group sponsor responsible for the administration of your health plan. A printed copy of the Coverage Manual further describing benefits for which you are eligible under your group health plan is also available, upon your request, from the department of your employer or group sponsor responsible for the administration of your health plan.

This notice is attached to an electronic copy of the Coverage Manual for your group health plan. Wellmark Blue Cross and Blue Shield of Iowa is not responsible for any alterations or modifications that may be made to an electronic copy or other differences that may exist between the attached electronic copy of the Coverage Manual and the printed Coverage Manual. Any alterations, modifications, or differences contained in the electronic copy to which this Notice is attached that are not consistent with, or that conflict with, the printed Coverage Manual issued to your employer or group sponsor are not binding on Wellmark Blue Cross and Blue Shield of Iowa. In the event of any inconsistency or conflict between the printed Coverage Manual and an electronic copy, the terms of the printed Coverage Manual shall govern.

IOWA LABORERS DISTRICT COUNCIL HEALTH
AND WELFARE TRUST FUND

Laborers
Building Trade
Heavy Highway-Laborers
Teamsters
Trowel Trade
Ironworkers
2008 COVERAGE MANUAL

SUMMARY PLAN DESCRIPTION
2008
TABLE OF CONTENTS

TABLE OF CONTENTS	1
INTRODUCTION	2
ELIGIBILITY RULES	3
INITIAL ELIGIBILITY FOR ACTIVE EMPLOYEES	3
CONTINUATION OF ELIGIBILITY FOR ACTIVE EMPLOYEES	3
SELF PAYMENT OF CONTRIBUTIONS	4
DISABILITY HOURS CREDIT	3
CONTINUATION OF ELIGIBILITY IN EVENT OF EMPLOYEE’S DEATH.....	6
TERMINATION OF ELIGIBILITY – MILITARY SERVICE.....	6
REINSTATEMENT OF ELIGIBILITY	7
RETIREE PROGRAM	7
CHANGE OF ELIGIBILITY RULES (ALL CLASSIFICATIONS)	8
EFFECTIVE DATES OF COVERAGE	9
ELIGIBLE DEPENDENT DEFINED	9
TERMINATION DATES OF COVERAGE	10
“COBRA” CONTINUATION COVERAGE	11
EXCLUSIONS FROM COVERAGE	12
CLAIMS DETERMINATION, REVIEW AND APPEAL PROCEDURES	13
OTHER IMPORTANT INFORMATION	16
TRUSTEES AS SOLE JUDGES	16
SUBROGATION	16
CONFIDENTIALITY AND RELEASE OF INFORMATION (HIPPA)	17
COORDINATION OF BENEFITS	17
OTHER INFORMATION (ERISA)	17
STATEMENT OF PARTICIPANT RIGHTS (ERISA)	18
DENTAL CARE BENEFITS	20
VISION CARE BENEFITS	24
PRESCRIPTION DRUG BENEFITS	25
DEATH BENEFITS	26
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	26
SHORT TERM DISABILITY BENEFITS.....	28
HEATH REIMBURSEMENT ACCOUNT.....	29
WELLMARK BENEFITS CERTIFICATE	BALANCE OF BOOK

IOWA LABORERS DISTRICT COUNCIL HEALTH AND WELFARE TRUST

2415 Ingersoll Avenue

Des Moines, IA 50312

Locally in Des Moines: (515) 280-5348 or toll free at (866) 280-5348

Dear Participant:

We are pleased to provide you as a participant with your new Summary Plan Description. The Iowa Laborers District Council Health and Welfare Trust first teamed with **Wellmark Blue Cross Blue Shield** for your health care benefits in January of 2004 and continues with that relationship. This relationship provides you with a broad network of hospitals and physicians throughout the United States. All hospitals in Iowa and over 97% of the physicians in Iowa are members of the Blue Card network.

It remains important that you keep the fund office notified about any change in your address or your dependents. Should you change address or have a change in your dependents you should contact the fund office: Locally, in Des Moines at: **(515) 280-5348** or toll free at: **(866) 280-5348**.

The Board of Trustees administer all provisions of your plan. Hospital and Medical benefits are processed and paid though Wellmark Blue Cross Blue Shield. You will receive a identification card for the Wellmark Blue Cross Blue Shield network. Dental benefits, Vision benefits, and Death or Disability benefits are processed though **Benefit Management Group, Inc.** No separate identification card is necessary for Dental benefits, Vision benefits, or Death or Disability benefits. Prescription Drug benefits are processed and paid by the Trust's pharmacy vendor, **NMHC**. You will receive a separate identification card for prescription drug benefits.

You may call **Wellmark's** Customer service line at **(800) 524-9242** if you have questions regarding the benefits of their network.

You may call **NMHC's** Customer service line at **(888) 354-0090** if you have questions regarding your prescription drug benefits.

You may call Benefits Management Group, Inc. at its Customer service line at **(319) 365-2810** if you have questions regarding your dental, vision or death benefits.

Questions about eligibility should be addressed to the Fund Office: In Des Moines: **280-5348** or toll free at **(866) 280-5348**.

Sincerely

Board of Trustees

Iowa Laborers District Council Health and Welfare Fund

ELIGIBILITY RULES

All Employees*, working for a contributing Employer or Employers under the terms of a Collective Bargaining Agreement within the jurisdiction of the Fund shall be eligible to receive benefits after meeting the following eligibility requirements.

***NOTE:** The designation of Employee may not include an individual who is an Owner of the Employer or the spouse of the Owner of the Employer unless as to such individual contributions on behalf of said individual are made on the basis of 40 hours per week for each week during a calendar year (2,080 hours per calendar year). For the purposes of this paragraph the Employer is the business entity (no contributions may be paid on behalf of the owner or spouse of the owner of a sole proprietorship or partnership notwithstanding the percentage of ownership) which has executed the Collective Bargaining Agreement as Employer. For the purposes of this paragraph the Employee is an individual providing services to the Employer within the classification of individuals covered under the Collective Bargaining Agreement and according to the terms of the Collective Bargaining Agreement. For the purposes of this paragraph an Owner or spouse of the Owner is an individual or the spouse of an individual who owns a twenty-five percent (25%) or greater interest in the business entity (may not be a sole proprietorship or partnership) which has executed the Collective Bargaining Agreement as Employer.

Initial Eligibility For Active Employees:

You will become initially eligible for benefits under the Plan on the first day of the month after you have worked for contributing Employer or Employers of at least 600 hours worked within a consecutive 12 month period. Your initial eligibility will be for the balance of the eligibility quarter in which initial eligibility is met as defined above plus, if the initial eligibility is less than a full eligibility quarter, the next following eligibility quarter.

Continuation Of Eligibility For Active Employees:

After becoming initially eligible for benefits under the Plan continued eligibility is based on Contribution Quarters and Benefit Quarters as follows:

CONTRIBUTION QUARTERS	BENEFIT QUARTERS
Work Performed During	Determines Eligibility for
December, January, February	May, June, July
March, April, May	August, September, October
June, July, August	November, December, January
September, October, November	February, March, April

Employer Contributions: After becoming initially eligible, you continue to be eligible as long as you are working for a contributing Employer or Employers and those Employer(s) make contributions to the Fund on your behalf for at least 375 hours in each Contribution Quarter as defined above. The quarterly hour requirement may be changed by the Trustees to represent the actual average expense for operating the Plan. Hours received on a reciprocal basis from reciprocating jurisdictions will be adjusted to reflect the dollar equivalent for posting to this fund.

Reserve Accumulation Account (“Hour Bank”): When you work more than the number of hours required by these Rules for eligibility, your excess hours are credited to your Reserve Accumulation Account or “Hour Bank” and are used to continue your eligibility if you do not have enough normal contributions at a later date. Reserve hours credited to the Employee each Contribution Quarter are automatically used if necessary to continue your eligibility. You earn credit for “excess” hours, if any, immediately beginning on the date you are initially eligible in this Plan.

You may accumulate “excess” hours to your Hour Bank for a maximum of 750 hours. Accumulated hours may be adjusted based on any change to the Employer Contribution rate.

The Reserve Accumulation Account or “Hour Bank” is calculated separately for each Employee, but it is not a savings account that the Employee “owns” or that he can withdraw cash from. Excess hours accumulated to the Hour Bank will be applied only to maintain the Employee’s eligibility for coverage in this Plan.

Your Reserve Accumulation Account or Hour Bank may not be used if you are not available for work at Covered Employment in the Industry with an Employer who participates in this Fund. If your Employer or the Local Union in which you are a member withdraws from participation in this Fund your Reserve Accumulation Account may not be used and will be forfeited. If you leave covered employment and commence work for an employer who is not a participating Employer with this fund your Reserve Accumulation Account may not be used and will be forfeited.

An individual Participant may remain eligible under this Plan when not available for work at Covered Employment because of a change in their Union affiliation. A Participant must submit written notification of the change in work status and satisfy each of the following requirements to remain eligible:

1. The participant continues to work for the same employer,
2. Contributions are made to another Multiemployer Fund,
3. The hours worked and the monthly contributions to the other Fund are available so the Fund Administrator can verify continuity of employment, and
4. The maximum extension of the Hour Bank or Self Payment period is limited to the earlier of two Quarters (6 months) or the satisfaction of the new Plan’s initial eligibility requirement.

Self-Payment of Contributions: After becoming initially eligible, you may be allowed to make self-payments of 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 at covered employment in the Industry with an Employer who participates in this Fund. If you commence work for a non-participating Employer in the Industry you will not be eligible to make self-payments.

Your self-payment is equal to 375 hours times the hourly rate in effect for contributing Employers. The self-payment hours requirement is reduced by hours worked in the most recent Contribution Quarter, if any. Failure to make the self-payment to supplement the remainder of your Hour Bank will forfeit the Reserve Accumulation Account or “Hour Bank” balance and you will have to meet the Initial Eligibility requirements to reinstate coverage.

If you elect self-payment of contributions, you can extend eligibility for three (3) quarters under the rules. If you elect self-payment of contributions **you will not be entitled to COBRA continuation** at the end of the self-payment period.

Self-payments must be received at the Fund Office by the date shown on the Self Payment or Termination Notice. All Notices are sent by mail to the last known address on file at the Fund Office, so it is important that any address changes are reported immediately.

Eligibility by means of self-payment can be continued for a maximum of 3 successive Benefit Quarters. For the purposes of this Rule, a self-payment made to supplement an amount remaining in your Hour Bank will be considered your first self-payment.

You must make self-payments of contributions for consecutive benefit Quarters so that your eligibility is continuous. After making 3 consecutive self payments you will have to meet the Initial Eligibility requirements to reinstate coverage.

Continuation of Coverage By Use of Reserve Accumulation Account During Disability:

If you become totally disabled while you are eligible in this Plan, your eligibility may be continued with the use of your Reserve Accumulation Account.

Disability Hours Credits:

In addition to continuation with the use of your Reserve Accumulation Account you may also be entitled to Disability Hours Credits. To Qualify for Disability Hours Credits, you must be unable to perform covered employment and must submit evidence satisfactory to the Trustees that you are either medically certified as unable to perform covered employment or are eligible for Weekly Workers' Compensation Benefits as a result of disability incurred within the jurisdiction of any Local Union participating in this plan.

Twenty-five (25) Disability Hours will be credited for each full week of such disability, up to a maximum of 375 credited hours:

1. For any single period of disability, or
2. For all disability hours credited in any continuous twelve calendar month period.

All disability absences will be considered as a single disability unless:

1. You return to active covered employment for at least one day and you submit evidence satisfactory to the Trustees that the causes of the latest disability absences cannot be connected with the causes of any prior disability absences, or
2. You return to active covered employment for at least:
 - a. 375 hours in three consecutive calendar months, or
 - b. 750 hours in six consecutive calendar months,even though a connection can be established between the causes of two successive disability absences.

The Trustees retain the right to have you medically examined by a physician of their own choice at the Plan's expense to determine whether a disability qualifies under this rule.

Self-Payment of Contributions During Total Disability:

If you are totally disabled but you are not eligible for Medicare when you have exhausted your Reserve Accumulation Account, you may continue eligibility for yourself and eligible Dependents, if any, by means of self-payments for up to an additional ten Benefit Quarters or until the earlier of:

1. The date you are no longer totally disabled, or
2. The date you become eligible for Medicare.

To be considered Totally Disabled you must be:

1. Receiving a Social Security Disability Benefit, and
2. Unable to perform **any** work for remuneration or profit on the date you would otherwise lose eligibility under these Rules.

Return to Work from Disability Reinstatement:

When you return to work from a continuation of eligibility by disability, your eligibility continues under the disability section of these Rules for a limited time while you work the 375 hours necessary for reinstatement as an active Employee. You are allowed:

1. The remainder of the Benefit Quarter in which you return to work, plus
2. The next following Benefit Quarter.

If you fail to work the necessary hours in the specified time, your eligibility as an active Employee is determined as described in the Initial Eligibility section of these Rules.

Continuation of Eligibility For Dependents in the Event of an Employee's Death:

If you die while you are eligible under these Rules, your eligible dependents may continue to be eligible according to the following requirements.

Automatic Continuation: Eligibility for your surviving dependent(s) will be continued automatically, without self-contribution, so long as they continue to meet the definition of dependent(s) until the normal eligibility termination date based on your employment record and your Reserve Accumulation Account.

Self-Payment of Contributions: Eligibility for your surviving dependent(s) may be continued by self-payment of contributions at rates established for the Retiree Program after the automatic continuation is exhausted. Your surviving dependents will be eligible to make self-payments under this section only if:

1. You were eligible at the time of death, and
2. You were eligible in this Plan during at least twelve (12) of the twenty (20) Coverage Quarters immediately before death.

The self-payment required is equal to the cost of the benefit program, including administration expenses, as determined by the Trustees from time to time. Self-payments will be accepted to continue your surviving Dependents' eligibility for coverage under the Schedule of Benefits normally available to active Employees until the earlier of:

1. The date your Dependent spouse remarries, or
2. The date your Dependent child no longer meets the definition of Dependent, or
3. The date your Dependent becomes eligible under any other group health care program.

Coverage for surviving Dependents must be continuous. Eligibility cannot be granted or reinstated under this Section if:

1. Timely self-payments are not made when the surviving Dependents are first eligible to do so, or
2. Timely self-payments are not made as required after becoming initially eligible under this Section.

Benefit Limitations:

Surviving Dependents who are eligible to make self-payments can elect whether or not to continue eligibility. Surviving Dependents are NOT covered by:

1. Death Benefits, or
2. Accidental Dismemberment Benefits, or
3. Pregnancy Expense Benefits (unless conception occurred before the Employee's death).

All other normal plan provisions apply.

Termination of Eligibility For Employees and their Dependents When Entering Military Service:

An Employee's or a Dependent of an Employee's eligibility will cease the day he or she is inducted into the Armed Forces of the United States. When you as an Employee are inducted, your dependents' eligibility terminates on the last day of the Benefit Quarter in which the induction occurs.

Your accumulated eligibility, if any, will be kept on the records of the Trust, provided you notify the Fund Office, in writing, that you are entering the Armed Forces of the United States. Such accumulated eligibility will be made available to you upon discharge and return to work for a contributing Employer. If covered employment is available and you are physically fit, you must return to work for a contributing Employer within ninety (90) days after discharge to retain your right to your eligibility. Your eligibility and that of your dependents, if any, is then reinstated on the first day of the month after your discharge **and** your return to work for a contributing Employer, provided you were eligible when inducted.

If you fail to return to work for a contributing Employer within ninety (90) days from the date you are discharged, your accumulated eligibility will be forfeited and you must again satisfy the initial eligibility requirements of these Rules.

Reinstatement of Eligibility

Employees: If you once established eligibility under this Plan and lose that eligibility at a later date, you may be reinstated under "Continuation of Eligibility" in these Rules, if you have been ineligible less than six (6) consecutive months. If you remain ineligible six (6) consecutive months or more, then you must meet the requirements under "Initial Eligibility" in these Rules to reinstate eligibility.

If you are not actively at work due to disability on the day you would otherwise reinstate your eligibility, you will not become eligible for Benefits from this Plan for that period of disability. Your eligible Dependents, if any, become eligible for Plan Benefits immediately on the normal effective date, unless they too are disabled.

Dependents: A dependent child who loses eligibility for reasons other than age (such as a change of employment or residence) may have eligibility reinstated on the first day of the month after which the child again meets all the requirements of the Dependent definition, provided the child has not remained ineligible more than twelve (12) consecutive months. If a Dependent child remains ineligible more than twelve (12) consecutive months, eligibility as a Dependent cannot be reinstated.

Retiree Program:

General Eligibility Requirements:

Each normal or early retired Employee may continue coverage for himself and his eligible dependents through this Plan under the Retiree Program provided he/she meets all of the following requirements:

1. He/She has been eligible in this Plan at least 12 of the 20 Coverage Quarters immediately before his/her retirement; and
2. He/She is eligible in this Plan at the time of his/her retirement.

Some proof of retirement status will be required. If you are eligible to participate in the Retiree Program, you must exercise that option when first eligible to do so. If you do not exercise your option to participate in the Retiree Program immediately upon retirement; or if there is an interruption in coverage, you will not be allowed to begin participation at a later date.

Only those persons who are eligible dependents at the time of your retirement can be covered under the Retiree Program. A new dependent (spouse or children) cannot be added under the coverage after your retirement begins.

Required Enrollment With Medicare:

When you or your Dependent becomes eligible for Medicare (officially known as Title XVII of the Social Security Amendments of 1954, amended effective July 1, 1973, and as thereafter may be amended) in

addition to this Plan, the Trustees require that you enroll in Medicare (both Part A and Part B). This applies whether you are eligible due to attained age or to a qualifying disability.

You or your Dependent will be considered to be currently eligible and covered by Medicare as soon as you would be eligible to enroll whether or not you actually enroll as you are required. To comply with Federal regulations, this provision will not apply to an Employee who is still eligible in this Plan due to Employer contributions or to the spouse of such an Employee.

Coverage Classifications Defined:

Employees eligible to participate in the Retiree Program and their eligible dependents, if any, are covered under one of two benefit classes, depending on whether the covered person is also eligible for Medicare.

CLASS Medicare Ineligible: Coverage for retired Employees and/or their eligible dependents who **ARE NOT** eligible for Medicare.

CLASS Medicare Eligible: Coverage for retired Employees and/or their eligible dependents who **ARE** eligible for Medicare.

For example, you and your spouse would both be covered under Class Medicare Ineligible coverage if neither of you are eligible for Medicare. If you are eligible for Medicare and your spouse is not, you would be eligible under Class Medicare Eligible coverage and your spouse would be eligible under Class Medicare Ineligible coverage.

Self-Payment of Contributions:

Self-Payments are required on a monthly basis at the beginning of the month of coverage. A change in coverage circumstances (such as eligibility for Medicare) will predetermine the covered person's benefits classification effective the first day of the calendar month coincident with or next following the date the change in circumstances occurs. Rates are based on your Medicare eligibility. It is important that you keep the Fund Office aware of any changes.

Benefit Limitations:

All normal Plan provisions apply to Retiree Program coverage. Employees and their dependents eligible in Class Medicare Ineligible or Class Medicare Eligible are **NOT** covered by:

1. Death or Accidental Death and Dismemberment Benefits; or
2. Pregnancy Expense Benefits and Newborn Dependent Child Benefits.

Change of Eligibility Rules (All Eligible Classifications):

The Trustees, in their discretion, are empowered to change or to amend these Eligibility Rules at any time.

A Note of Explanation: The Eligibility Rules represent the requirements which must be satisfied for you and your dependents to become and to remain eligible for benefits from this Plan. In the event the requirements are not satisfied, eligibility is lost and benefits are not payable. The Trustees reserve the right to deny benefits to any claimant who is, in their opinion, attempting to subvert the purpose of the Plan or who does not present a bona fide claim.

Remember: Changes in employment may have an effect on Employer contributions paid in your behalf. For example, Employer contributions cease in the event you:

1. Change job classifications from covered to non-covered employment, **even if that employment is with the same employer;** or
2. Change employment from a participating to a non-participating Employer.

You and your dependents may obtain, upon written request to the Union Office, information as to the address of a particular Employer and whether that Employer is required to pay contributions to the Plan.

Effective Dates Of Coverage:

Employee:

Your effective date of coverage as an Employee will be the date you satisfy the requirements of these eligibility rules.

Dependents:

Your effective date of coverage as a Dependent will be the date the Employee who sponsors you through family coverage becomes eligible or the date you first satisfy the definition of Dependent, whichever is later.

The newborn child of an Eligible Employee becomes eligible on the date of birth.

Eligible Dependents Defined:

Eligible Dependents are the following:

1. The legal spouse of the eligible Employee; or
2. Any unmarried natural child of the eligible Employee and the legal spouse, excluding a person who would otherwise be entitled to benefits under this Plan as an employee, if:
 - a). the child is less than 19 years old; or
 - b). the child is less than 25 years of age provided that such child is enrolled in an accredited educational institution (see definition) and is considered a full-time student at the institution and is dependent on the Employee for the major portion of their financial support. Written proof of full-time enrollment must be submitted for each semester.
 - c). the child is over 19 years of age and he/she is totally and permanently disabled because of a qualifying physical or mental disability. To be considered a qualified physical or mental disability under this definition, it must:
 - 1). Occur before the child reaches age 19 or while the child was a full-time student under 25 years of age, and the child must have had continuous creditable coverage without a break of 63 days or more since on or before the child turned age 19 or while the child was a full-time student under 25 years of age; and
 - 2). be certified by a Physician; and
 - 3). Render the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance.Initial proof of such disability and financial dependency must be furnished to the Trustees within 60 days of the child's reaching 19 years of age. Subsequent proofs may be required by the Trustees after the child reaches age 21, but not more frequently than annually.
3. Your natural child, or a legally adopted child, including the legally required trial period prior to the approval of the adoption by a court, or a stepchild. In order to qualify under the definition of an eligible dependent the following conditions must be met:
 - a). the child must be living with the Eligible Employee in a regular parent-child relationship, except in the case of divorce; and
 - b). the Employee contributes more than 50% toward the maintenance and support of the

- child; and
- c). legal documentation is presented, upon request, supporting the Dependent's status.

It is understood that coverage of a dependent child may also be established in those cases where the Trust Fund has received a "Qualified Medical Child Support Order" (QMCSO) entered by an appropriate court as defined under applicable federal law. Normally, such an order will be issued in a divorce or other family law action which recognizes the child's right to health benefits under the Plan.

Dependent coverage terminates on the date:

- 1). the eligible child marries; or
- 2). the qualifying disability ceases; or
- 3). the Dependent is employed on a full-time basis; or
- 4). the QMCSO terminates; or
- 5). the Employee's coverage is terminated.

The term Eligible Dependent does not include a child fathered by a Dependent child or delivered by a female other than the eligible Employee or the Employee's legal spouse. The term Eligible Dependent does not include a foster child or a child for whom you have legal guardianship.

Educational Institution:

"Educational Institution" means an accredited trade school, college or university or other organization whose primary purpose is training and which regularly charges tuition for such training.

"Educational Institution" does not include "work-study" or other training programs during which the trainee receives compensation.

Termination Dates of Coverage:

Employee:

Your coverage as an Employee under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

- 1). Failure to meet the requirements for continuing eligibility as shown in the Eligibility rules, including a failure to make any self-payments of contributions in a timely manner; or
- 2). Termination of the coverage classification under which you were continuing your eligibility; or
- 3). Termination of the Plan itself.

Dependents:

Your coverage as a Dependent under all benefit provisions of the Plan terminates when the earliest of the following events occurs:

- 1). Termination of the Eligibility for the Employee who sponsors you; or
- 2). On the first of the month next following the date you fail to meet the definition of Dependent; or
- 3). Failure to meet the requirements for continuing eligibility as shown in the Eligibility Rules, including failure to make any self-payments of contributions in a timely manner; or
- 4). Termination of the coverage classification under which you were continuing your eligibility; or
- 5). Termination of the Plan itself.

“COBRA” CONTINUATION COVERAGE

Employee:

If you are an eligible Employee, you can choose continuation coverage for up to 18 months if you lose eligibility due to:

1. A reduction in your hours of covered employment; or
2. The termination of your covered employment.

The election of COBRA must be made when you first lose eligibility as a covered employee, not at the end of your self-pay extension of coverage.

Spouse:

If you are the Dependent spouse of an eligible Employee, you can choose continuation coverage for up to 36 months if you lose eligibility due to:

- 1). The death of your spouse; or
- 2). The termination of your spouse's covered employment or a reduction in your spouse's hours of covered employment; or
- 3). A divorce or legal separation from your spouse; or
- 4). Termination of your eligibility because your spouse becomes eligible for Medicare.

Dependent Children:

If you are the Dependent child of an eligible Employee, you can choose continuation coverage for up to 36 months if you lose eligibility due to:

- 1). The death of a parent; or
- 2). The termination of your parent's covered employment or a reduction in their hours of covered employment; or
- 3). A parent's divorce or legal separation; or
- 4). Termination of your eligibility because a parent becomes eligible for Medicare; or
- 5). Your failure to meet the definition of "Dependent child" contained in the Plan.

Eleven (11) Month Extension of Continuation Coverage for Disabled Qualified Beneficiaries:

If the eligible Participant is disabled (as determined by the Social Security Administration) at the time of a Qualifying Event involving termination of employment or a reduction in hours, the eighteen (18) month continuation period may be extended eleven (11) months, up to a maximum of twenty-nine (29) months for the disabled individual. The eligible Participant is responsible for electing the additional eleven (11) months of continuation coverage and notifying the Fund Office within the time frames described herein.

Notice is Required:

The Employee or an eligible family member has the responsibility to inform the Fund Office within 60 days of a divorce, legal separation or a child losing dependent status.

Application for COBRA Benefit:

The Fund Office will provide you with specific instructions, self-payment rates and benefit descriptions once

your notice is received and if you qualify under COBRA. Your eligibility for COBRA continuation coverage depends on you making the required self-payments in a timely manner. If you fail to make a timely payment of any required contribution, coverage will terminate and cannot be reinstated.

Limitations:

In addition to the limits stated above, your rights to COBRA continuation terminate when the earliest of the following events occurs:

- 1). The date on which you are or become entitled to Medicare;
- 2). The date on which you are or become entitled to coverage under another group health program;
- 3). The date you fail to make the self-contribution in the amount and by the time required.

If more than one qualifying event occurs (such as a divorce which happens during a lay-off), the maximum continuation period is 36 months from the date of the first qualifying event; coverage periods are not additive.

Only persons eligible in the Plan on the date of the original qualifying event are eligible for COBRA continuation coverage. Newly married spouses and any children (newborn or adopted or step children) who were not eligible in the Plan on the date of the qualifying event cannot be added to COBRA continuation coverage.

Qualified Medical Child Support Orders (QMCSO): This Plan has established procedures governing the determinations of Qualified Medical Child Support Orders and a copy of such procedures may be obtained at no cost upon request to the Fund office.

Exclusions From Coverage Applying to All Provisions Under the Plan

Self-Inflicted Injury or Substance Abuse: Payment *will not* be made for self-inflicted injury, suicide or attempted suicide. This exclusion does not apply if the self-inflicted injury, suicide or attempted suicide results from or is attributable to a medical condition or domestic violence.

Treatment Without Charge: Payment *will not* be made for confinement in any hospital or treatment by any physician when the hospital or physician makes no charge that the Eligible Person is legally required to pay or would not be charged in the absence of these benefits.

Illegal Occupation or Commission of Felony: Payment *will not* be made for loss to which a contributing cause was the commission of or attempt to commit a felony by the person whose injury or sickness is the basis of claim, or to which a contributing cause was such person's being engaged in an illegal act or occupation.

Acceptance of Extraordinary Risk: Payment *will not* be made for any loss caused by, incurred for or resulting from the voluntary acceptance of extraordinary risks. For the purposes of this provision extraordinary risks are defined as engaging in speed contests whether sanctioned or not sanctioned (including drag racing, street racing, or other racing activities), engaging in fighting whether sanctioned or not sanctioned, bungee jumping, sky diving, or any other activity which a reasonable person would consider to involve reckless behavior engaging in which would likely result in an inherent risk of death or injury. This exclusion does not apply if the extraordinary risk results from or is attributable to a medical condition or domestic violence.

Future Medical Expenses for Settled Claim: Benefits of this Plan *do not cover* future medical expenses for any illness or injury caused by a responsible third party individual or entity for which you or your eligible dependent have accepted a settlement or received an award.

Liability for Accidental Injuries: Benefits under this Plan are considered secondary and excess coverage, including but not limited, to any automobile insurance or common carrier's liability (such as bus or commercial airline). No payment shall be made until proof is submitted to and judged acceptable by the Trustees that a proper claim has been made for other coverage. Normal Plan benefits shall be paid if other coverage has been

denied or shall be coordinated with other coverage payments, if any.

Other Exclusions and Limitations:

Additional limitations apply to each category of benefits provided under the plan of benefits and are contained in each benefit description of this Summary Plan Description or the Benefits Certificate of Wellmark Blue Cross Blue Shield.

Claims Determination, Review and Appeal Procedures:

***NOTICE:** The following Claims Determination and Review provision of this Summary Plan Description **does not apply to the Wellmark Blue Cross and Blue Shield Medical Plan.** Please refer to the medical plan Benefit Certificate for the applicable provisions relating to Section 5: Filing Claims – The Claim Filing Process.*

Claims Determination and Review:

When your claim is received by the Plan, it will be assigned to the Claims Processor for review and determination. If you or your authorized representative has not followed the correct procedures, you or your authorized representative will be contacted within five days (or 24 hours in the event of an urgent care claim) to notify you of the proper procedures for submitting your claim. This notification may be oral, unless written notification is requested by the claimant or authorized representative.

If the Claims Processor determines that your claim is payable under the terms of the Plan, the claim will be paid as provided under the terms of the Plan. If the Claims Processor determines that your claim will be denied (in whole or in part) you will receive a written notice setting out:

- A specific reason for the denial;
- A reference to the specific plan provision upon which the denial is based;
- Any additional information or material necessary to perfect the claim and why such information or material is necessary;
- A description or reference to the Plan's review procedures and applicable time limits;
- If the denial is based on an internal rule, guideline, protocol, or another, similar criterion, a statement identifying the rule and explaining that you may request a copy free of charge, and;
- If the denial is based on a medically necessary or experimental treatment or similar rationale, a statement that an explanation will be provided free of charge upon request.

If your claim is a pre-service claim, the Claims Processor will notify you of its determination not later than 15 days after receipt of the claim. If an extension of time is necessary, the Plan may extend the time to respond to your claim for up to an additional 15 days. If this becomes necessary, you will be notified of the extension prior to the expiration of the initial 15 day period. If additional information is required, the Plan will notify you, and you will have up to 45 days from the date of the notice to provide the additional information.

If your claim is a post-service claim, the Claims Processor will notify you of its determination not later than 30 days after receipt of the claim. If an extension of time is necessary, the Plan may extend the time to respond to your claim for up to an additional 15 days. If this becomes necessary, you will be notified of the extension prior to the expiration of the initial 30 day period. If additional information is required, the Plan will notify you, and you will have up to 45 days from the date of the notice to provide the additional information.

If your claim is an urgent care claim, the Claims Processor will notify you of its determination as soon as possible, but not later than 72 hours after receipt of your claim.

Claim Review:

If your claim is denied, and if, after reading the explanation, you feel that the action taken on your claim may

be incorrect, you should immediately ask the appropriate provider to review your claim with you.

To review **prescription drug claims** you should call **(800) 645-3332**.

To review **dental, vision or death claims** you should call **(319) 365-2810**.

At that time, the appropriate provider will let you know if there is any additional information which might enable your claim to be reconsidered.

If your claim is considered to be an urgent care claim you should notify the appropriate provider that it is an urgent care claim. The determination of whether or not your claim is to be treated as an urgent care claim is determined by your treating medical care professional.

All reviews will be given a full and fair review without giving deference to the earlier claim determination by an appropriate, named fiduciary of the Plan who was not involved in the original claim decision and who is not a subordinate of the individual who made the original decision. In this review the following may be required:

- The individual conducting the review may require additional documents as it deems necessary;
- You may, upon request and free of charge, review and have copies of all relevant documents, records, and other information relating to the claim that are in the possession of the Plan;
- You may request the names of any medical professionals who were consulted during the claims review process;
- You may submit written comments, documents or any other information you believe is relevant;
- If the determination of your review is based in whole or in part on a medical judgment, the reviewer will also consult a different health care professional than any used in the initial claims determination.

- The Plan will notify you of the results of your claims review within a reasonable period of time after receipt of your request for review, but no later than the following:
 - Pre-service claims – 30 days following receipt of your request for review; or
 - Post-service claims – 60 days following receipt of your request for review; or
 - Urgent care claims – 72 hours following receipt of your request for review.

Claims Appeals to the Appeal Committee and Board of Trustees (And voluntary appeals from denials by Wellmark Blue Cross and Blue Shield Medical Plan):

*NOTICE: The following Claims Appeals provisions of this Summary Plan Description **do not** apply to the Wellmark Blue Cross and Blue Shield Medical Plan. For claims appeals of a denied claim under the Wellmark Blue Cross and Blue Shield Medical Plan please refer to the medical plan Benefit Certificate for the applicable provisions relating to Section 5: Filing Claims – Appealing a Denied Claim.*

The following provisions apply to appeals of denials relating to prescription drug, dental, vision or death claims and to properly requested voluntary appeals from denials by the Wellmark Blue Cross and Blue Shield Medical Plan. Voluntary appeals to the Board of Trustees from denials by the Wellmark Blue Cross and Blue Shield Medical Plan must be made within 60 days following the date of the adverse review decision.

Your decision to submit a voluntary appeal from an adverse decision of an appeal under the Wellmark Blue Cross and Blue Shield Medical Plan is subject to the following:

- You are not required to submit your claim to a voluntary appeal and your decision not to submit your denied claim does not prevent you from commencing a civil action under section 502(a) of ERISA.
- That the Plan waives any right to assert that you have failed to exhaust administrative remedies should you elect not to seek a voluntary appeal.
- If you choose to submit your claim to a voluntary appeal the Plan agrees that during the time that your voluntary appeal is pending any applicable statute of limitation or other defense based on timeliness is tolled.

- *You may only submit your appeal of a denied claim for voluntary claims appeal after exhaustion of your appeal rights under the Wellmark Blue Cross and Blue Shield Medical Plan.*
- *Your decision to submit or not submit your appeal of a denied claim for voluntary appeal will have no effect on your rights to any other benefits under the plan.*

Claims Appeals: If you are not satisfied with the action taken on your claim you or your duly authorized representative have the right to appeal. The Plan must receive your written request for an appeal of the claim denial within 180 days following the receipt of written notice of denial of your claim (or within 60 days following the receipt of written notice of the adverse review decision if a voluntary appeal from the Wellmark Blue Cross and Blue Shield Medical Plan). For death claim denials the Plan must receive your written request for appeal of the denial within 20 days of the date of the notice of appeal.

The procedures for the appeal to the Appeal Committee and/or the Board of Trustees are set forth below. These procedures have been established in accordance with Section 503 of the Employee Retirement Income Security Act and the final ERISA regulations issued under Section 2560.503.1.

Here's What to Do (Claim Procedure)

1. Notify the appropriate service provider in writing that you wish to have your claim reviewed by the Board of Trustees. If you wish, you may request a hearing before the Appeal Committee and/or the Board of Trustees.

Medical Claims Appeals should be directed to: Wellmark Blue Cross and Blue Shield of Iowa, 636 Grand Avenue, Des Moines, IA 50309-2565.

All other Claims Appeals should be directed to: Iowa Laborers District Council Health and Welfare Fund, Attention Fund Counsel, 2415 Ingersoll Avenue, Des Moines, IA 50312.

2. Your written request of an appeal (or a hearing if applicable) must be submitted within 180 days after you receive your written notice of denial (or within 60 days following the receipt of written notice of the adverse review decision if a voluntary appeal from the Wellmark Blue Cross and Blue Shield Medical Plan). For death claim denials the Plan must receive your written request for appeal of the denial within 20 days of the date of the notice of appeal.
3. Include in your written request all the facts regarding your claim as well as the reasons(s) you feel the original decision was incorrect.

Upon your request, the Fund Office will assist you in gathering the pertinent data from Fund records to complete the information you need for review of your claim.

4. In the event you request a hearing, you can appear in person or choose a representative to appear for you before the Appeal Committee and/or the Board of Trustees.

The Fund Office will notify you of the date, time and place to appear. In scheduling a hearing, every effort will be made to arrange a time that is convenient for you.

5. If you do not wish to make a personal appearance before the Appeal Committee and/or the Board of Trustees, the Administrative Manager will present your written statement and other pertinent information on your behalf.
6. You will receive the Board of Trustee's decision in writing. The written notice will contain: the decision, reasons for the decision, and specific references to pertinent Plan provisions on which the decision was based.
7. The written decision will be sent to you within 60 days after receipt of your written request for appeal.

8. You may, at your own expense, have legal representation at any stage of these review procedures. You must completely exhaust these Claims Review and Appeal Procedures before undertaking any legal action.

In reviewing your claim, every effort will be made by the Trustees to handle interpretations of the Plan and claim disputes in a consistent and equitable manner. In addition, the Trustees will make every effort to assure that you receive a full and fair review if your claim is denied.

If You Have Any Questions About These Review Procedures, Please Contact The Fund Office.

Other Important Information

Trustees as Sole Judges:

Wherever in the Plan or Trust Agreement the Trustees are given discretionary powers, they shall exercise such powers in a uniform and non-discriminatory manner. The Trustees shall, subject to the requirements of the law, be the sole judges of the standard of proof required in any case and the application and interpretation of the Plan and Trust Agreement, and decisions of the Trustees shall be final and binding.

All questions or controversies of whatsoever character arising in any manner or between any parties or persons in connection with the Plan or Trust Agreement or its operation, whether as to any claim for benefits, as to the construction of the language of the Plan or Trust Agreement or any rules and regulations adopted by the Trustees, or as to any writing, decision, instrument or account in connection with the operation of the Plan or otherwise, shall be submitted to the Board of Trustees for decision. In the event a claim for benefits has been denied, no lawsuit or other action against the Fund or its Trustees may be filed until the matter has been submitted for review under the ERISA-mandated review procedure set forth in the Trust Agreement. The decision or review shall be binding upon all persons dealing with the Plan or claiming any benefit hereunder, except to the extent that such decision may be determined to be arbitrary or capricious by a Court or arbitrator having jurisdiction over such matter.

Important: The Trustees of the Plan have full discretion to determine or define the amounts to be treated as covered expenses, reasonable and customary (R&C) charges, or medically necessary services and will determine the amount of benefits to be paid.

Subrogation:

The Trustees of the Iowa Laborers District Council Health and Welfare Fund have the right to and will use their rights of subrogation if you or an eligible Dependent receive benefits under any provision of this Plan for illness or injury for which another person or entity may be liable in whole or in part. Subrogation means that the Trustees have the right to assert a claim, by legal action if necessary, to the full sum of any benefits paid in your behalf by the Fund, from any person or entity who either caused or contributed to, in whole or in part, the illness or injury, or may be held liable, in whole or in part from any source, to you for payment for any illness or injury.

Your claims and benefit payments will normally continue to be paid in the same way as they were previously. However, you or your eligible Dependent will have certain responsibilities to the Iowa Laborers District Council Health and Welfare Fund as claimant. An Eligible Person who receives benefits from the Fund under these circumstances must sign and deliver all requested papers and forms to the Fund and must do whatever else is necessary to help the Fund administer this subrogation clause. An Eligible Person must not do anything or sign any document which may impair the Fund's right to recover the benefits paid relative to the loss. If you or your eligible dependent do not comply with the reasonable requests of the Fund your claims and benefit payments may be suspended or denied.

If you or an eligible dependent accept a settlement or receive an award, future medical expenses for any illness or injury caused by the responsible third party or entity are not eligible expenses under this Plan.

Confidentiality and Release of Information:

Your group sponsor is committed to protecting the privacy of your health information. It will request, use, or disclose your health information only as permitted or required by law. For example, your group sponsor has contracted with a third party administrator and other service providers to administer this group health plan and your other benefits and the third party administrator and other service providers 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 claims from physicians, hospitals, and other providers for covered services, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from you employer or group sponsor, to issue explanations of benefits to the person enrolled in the 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 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 will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, at your request we may release claim payment information to a friend or family member to act on your behalf during a medical procedure by submitting an authorization to release information to that person.

Coordination of Benefits:

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay or consider the balance due up to 100% of the total allowable expenses.

Other Information:

Name of the Plan: The Plan is the Iowa Laborers District Council Health and Welfare Trust Fund.

Name and Title of Each Trustee: The Trustees of this Fund are:

Management Trustees

Denis Reed, Secretary
Brett Nuckolls
Susan Kartman

Union Trustees

Steve Piper, Chairman
William Gerhard
Leonard Leo

James Piazza, Jr.

Gary Crees
Thomas Lytle

Employer and Plan Identification Numbers: The Employer Identification Number (EIN) issued to the Board of Trustees is 42-0946060; the Plan Number is 501.

Agent for Service of Legal Process: Board of Trustees, Iowa Laborers District Council Health & Welfare Trust Fund, 2415 Ingersoll Avenue, Des Moines, IA 50312. Service of legal process may also be made upon any Plan Trustee.

Fiscal Year of the Plan: The financial records of this Plan are based on a fiscal year which begins November 1 and ends October 31.

The Plan Can be Changed: The Trustees have the legal right to change the Plan, subject to any collective bargaining agreement that applies to it. Although the Trustees hope to maintain the present level of benefits and to improve upon them if possible, a primary concern of the Trustees is to protect the financial soundness of the Plan at all times. To do so may require Plan changes from time to time. Changes in the Plan may also be required in order to preserve the Fund's tax exempt status under Internal Revenue Service rules and regulations. These rules and regulations may change and as a result, Trustees may find it necessary to change Plan provisions so that the Trust does not lose its tax exempt status as a section 501(c)(9) Trust.

Right of Recovery: Whenever payments have been made by the Fund with respect to allowable expenses in excess of the maximum amount of payment necessary at the time to satisfy its provisions, the Fund shall have the right to recover such payments, to the extent of such excess, from (1) any individual to whom or for whom such payments were made; or (2) any insurance company, hospital, physician or any other organization. The Fund may also recover such excess payments by reducing future benefit payments, if any, which become due a Participant, Dependent or Beneficiary.

The Plan May be Terminated: Although the Trustees do not foresee that the Plan will be terminated, the Trust Agreement provides that termination may occur when: (1). The Trustees determine that the Trust Fund assets are not adequate to carry out the purpose for which the Welfare Fund is intended; or (2). There is no longer a collective bargaining agreement or other written agreement in effect that requires Employer contribution to be made to the Trust Fund and negotiations for extension thereof have ceased.

The Trustees are obligated to use the Trust Assets for payment of expenses incurred up to the date of termination and expenses related to the termination as their first priority. Remaining assets, if any, must be used to continue Plan benefits after the Plan termination date for those persons eligible when the Plan was terminated.

Upon written request, you may examine the agreement at the Administration Office or other specified locations. Or you may request a copy of the agreement which will be provided for a reasonable charge.

Statement of Participant Rights Information Required by the Employee Retirement Income Security Act (ERISA)

Introduction: You have probably heard about ERISA. ERISA stands for the Employee Retirement Income Security Act, which was signed into law in 1974. ERISA requires that Plan participants and beneficiaries be provided with certain information about their benefits, how they may qualify for benefits, and the procedures to follow when filing a claim for benefits. This information has already been presented in the preceding pages of this Summary Plan Description. ERISA also requires that participants and beneficiaries be furnished with certain information about the operation of the Plan and about their rights under the Plan. This information follows:

Your Rights as a Participant: As a participant in the Iowa Laborers District Council Health and Welfare Trust Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits: Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, and union halls, all documents governing the plan, including insurance contracts and collective bargaining 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 Pension and Welfare Benefit Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage: Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan: If you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Enforce Your Rights: If your claim for a welfare 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 a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 qualified 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.

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

Dental Care Benefits

YOUR ELECTION OF DENTAL CARE BENEFITS:

Introduction to Available Options

When you or your Dependent incurs expense for dental care, the Plan will pay expenses for or has arranged to provide services and supplies as described in this Section. You have two options for obtaining Dental Care benefits under the Plan.

Option I:

Participants choosing this Option may freely choose any licensed dentist practicing within the scope of his license. Charges incurred must be submitted on forms suitable to the Trustees for payment by the Fund Claims Office. Benefits under this option are **LOWER** than option II.

Option II:

Participants choosing this Option **DO NOT** have free choice of any licensed dentist in the community. Dental services and supplies **must be rendered** to Participants by particular dentists whose offices are part of a co-operative panel known as **The Dentist Company, Inc.** Co-payments and deductibles are administered by the dentist's offices themselves, without submitting claim forms to the Fund Claims Office.

NOTE: Services and supplies and benefit levels under the two Options are similar but **ARE NOT** identical.

Participants who become initially eligible **will be enrolled in Option II automatically** unless they specify Option I on their enrollment card and return the card to the Fund Office promptly (within 30 days).

After this initial choice, Participants may change their coverage Option **only once each year**, during an open enrollment period, to be effective each January 1.

Dental Care Benefits – Option One:

Free Choice of Provider Dentist

Annual Deductible Amount (per covered individual)..... \$25.00

Preventative and Diagnostic Services

Co-Payment Plan Pays 100%

Co-Payment..... Participant Pays 0%

Basic and Restorative Services

Co-Payment Plan Pays 80%

Co-Payment..... Participant Pays 20%

Major and Prosthodontic Services

Co-Payment Plan Pays 50%

Co-Payment..... Participant Pays 50%

Maximum amount Payable (aggregate of all Dental Care Benefits)..... \$900.00

..... Per Person per Benefit Year

Dental Care Benefits – Option Two:

Participating Panel Dentist

Annual Deductible Amount (per covered individual)..... \$25.00

Preventative and Diagnostic Services

Co-Payment Plan Pays 100%

Co-Payment..... Participant Pays 0%

Basic Services

Co-Payment Plan Pays 85%

Co-Payment..... Participant Pays 15%

Major Services

Co-Payment Plan Pays 50%

Co-Payment..... Participant Pays 50%

Maximum amount Payable (aggregate of all Dental Care Benefits)..... \$1,700.00

..... Per Person per Benefit Year

Beginning January 1, 2008 the following dental offices are the **only** participating dental offices under the Iowa Laborers District Council Health and Welfare Fund's **Option II** dental benefits.

Valley West Dental
Clocktower Professional Plaza
1720 28th Street, Suite C
W. Des Moines, IA 50266
(515) 224-4800

Lindale Dental Care
3730 First Avenue, N.E.
Cedar Rapids, IA 52402
(319) 362-2313

Windsor Hills Family Dentistry
3300 Windsor Avenue
Dubuque, IA 52001
(563) 557-7400

Dental Care Benefits – Definitions and Coverage:

When you or your Dependent incurs expense for dental care, the Plan will pay those expenses up to the reasonable maximum amount shown in the Schedule of Benefits and as described in this Section. The Plan requires co-payments for many types of care so you will share the cost of your treatment. Co-payment levels are specified for each group of eligible expenses. As used in this Dental Care Section, Benefit Year means the twelve calendar month period beginning each January 1st and ending the last day of the following December.

Predetermination of Benefits: You are not required to have the dentist submit an estimate of charges before work begins. However, the Trustees recommend that the dentist give the Claims Office a description of the procedures to be performed and the estimated fees before treatment starts if the total charges will be over \$100.00. This will let you and your dentist know if the treatment plan is considered reasonable and what benefits will be paid.

The Deductible Amount: The deductible amount is an amount that you have to pay from your own pocket before any Dental Care Benefits are payable. A deductible of \$25.00 is required each plan year for each individual covered under the Plan.

The Maximum Amount: All coverage under Dental Care Benefits is limited to the maximum amount. The maximum amount applies to you and each of your eligible Dependents separately.

The maximum amount for all Covered Expenses, other than Orthodontic Procedures, applies to coverage for treatment each calendar year and so is renewed each January 1st. Benefits not used in a prior year cannot be carried forward to increase the maximum amount for the next calendar year. The maximum amount covered under Dental Care Benefits – Option One is \$900.00 per individual. The maximum amount covered under Dental Care Benefits – Option Two is \$1,700.00 per individual.

Covered Expenses: Dental Care Benefits under Option I and Option II are divided into three main parts: Preventative and Diagnostic Expenses (such as routine examinations), Restorative Expenses (such as most fillings), Prosthodontic Expenses (such as gold work and dentures). The percentage payable by the Plan is determined separately for each type of treatment group.

Preventative and Diagnostic Services: The Plan pays 100% of the reasonable and customary expense for the following dental care:

1. Oral Examinations, not more than twice in a calendar year
2. X-Rays, consisting of:
 - (a) Bitewing x-rays, not more than twice in a calendar year.
 - (b) Full mouth x-rays, once in a 36 consecutive month period.
3. Preventative treatment, consisting of:
 - (a) Oral prophylaxis (cleaning and scaling of teeth) but not more than twice in a calendar year
 - (b) Topical sodium and stannous fluoride treatment is available only to Eligible Persons under age 19, but, in any event, not more than one treatment in a benefit year.
4. Space Maintainers for an Eligible Person under age 19.

Basic and Restorative Services:

The Plan pays 80% (85% under Option II) of the reasonable and customary expense for the following dental care:

1. Fillings, other than gold.
2. Injections of antibiotic drugs.

Major and Prosthodontic Services:

The Plan pays 50% of the reasonable and customary expense for the following dental care:

1. Initial installation of complete or partial bridgework fixed or removable.
2. Gold fillings (gold restorations are covered only as treatment, or decay or traumatic injury and only when teeth cannot be restored with a fill in material or when the tooth is an abutment to a covered partial denture or fixed bridge).
3. Inlays, onlays, crowns and pontics of any material.
4. Bridges, dentures or partials.

Treatment in Progress When Eligibility Terminates:

The Plan will generally **not pay** for services or supplies furnished after the date you or your Dependent's eligibility terminates, even if the Claims Office has predetermined the payments for a treatment plan submitted before the termination date.

The Plan will pay for services related to the following covered expenses if the Treatment is rendered during the calendar month immediately after the termination date and the following conditions are met:

1. A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan.
2. A crown if the dentist prepared the tooth for the crown while the patient was covered under the Plan.
3. Root canal therapy if the dentist opened the tooth while the patient was covered under the Plan.

Limitations:

OPTIONAL TREATMENT: In all cases in which there are optional plans of treatment carrying different fees, the Plan will cover the applicable percentage of the lesser fee(s). The covered individual will be responsible for 100% of the optional additional costs.

INLAYS, CROWNS, JACKETS. If the tooth can be restored with amalgam, silicate, or plastic materials but the patient prefers another type of restoration, the Plan will allow towards the chosen restoration the cost of the amalgam, silicate, or plastic restoration.

PARTIAL DENTURES. If a cast chrome or acrylic partial denture will restore the case, the Plan will allow the cost of such procedure toward a more complicated precision appliance that the patient and dentist may choose to use.

FULL DENTURES. If in the construction of a denture the patient and the dentist decide on a personalized restoration or employ specialized techniques as opposed to standard procedures the Plan will allow toward the non-personalized restoration or specialized technique only the benefit for the standard procedure.

APPLIANCES. Appliances or restorations necessary to increase vertical dimension or restore the occlusion or centric relationship are considered optional are not covered.

Exclusions:

Dental Care Benefits **are not** payable for:

1. Any service rendered and supplies ordered or treatment plan which began before coverage became effective;
2. Treatment other than by a licensed dentist or licensed physician, except that 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 the dentist;
3. Services or supplies that are primarily cosmetic in nature, including charges for personalization or characterization of dentures;
4. Replacement of a lost, missing or stolen prosthetic device;
5. Replacement or repair of an orthodontic appliance;
6. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer;
7. Services or supplies which are not necessary according to accepted standards of dental practice;
8. Services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are experimental in nature;
9. Any duplicate appliance or prosthetic device;
10. Sealants (other than to an Eligible Person under age 13);
11. A plaque control program (a series of instruction on the care of the teeth);
12. Periodontal splinting;
13. Services which are provided under other sections of this Plan;
14. Myofunctional therapy (correction of harmful habits) or oral hygiene or dietary instruction;
15. Implantology of individual teeth or dentures;
16. Charges associated with the initial installation of dentures or bridgework replacing a tooth or a group of teeth which were lost when not eligible for coverage in this plan;
17. A crown, gold restoration, denture or fixed bridge, if the work involves replacement or

- modification of a crown;
- 18. Any orthodontic procedures or Temporomandibular Joint Dysfunction (TMJ), including appliances or restorations or procedures for the purposes of splinting or to alter vertical dimension or restore occlusion;
- 19. Any charge eligible in whole or in part under any Health Care Benefits of the Plan;
- 20. Expenses for services other than those specifically indicated as covered.

Dental Care Benefits are also subject to all General Plan Exclusions and Limitations.

Extractions, Endodontic and Periodontal Services:

To avoid confusion and to more effectively cover the cost of certain dental procedures, the Iowa Laborers’ District Council Health and Welfare Trust have elected to cover services rendered for certain extractions (impacted and partially impacted teeth), endodontic and periodontal claims, and Specialized Pedodontic Treatment of Schedule II and Schedule III Care (subject to the standard of care and treatment in the community in which Provider practices) under the major medical benefits of the Health and Welfare Plan up to a lifetime maximum of \$2,000.00. The major medical deductible or a \$25.00 per person deductible per calendar year will apply. Benefits are payable at 80% of reasonable and customary charges. Benefits under this provision are in addition to the benefits set forth under Dental Benefits – Option 1 or Option II. Benefits under this provision are also subject to the limitations as set forth above for Dental Benefits and are also subject to all General Plan Exclusions and Limitations. All Option II care under this provision shall be by referral by the participating panel provider and such referral shall be solely for the treatment or procedure referred. Upon completion of the treatment referred the covered individual must return to the Option II participating panel provider for all future treatment.

Orthodontic Expenses:

The Plan has added an orthodontic benefit for each covered eligible dependent age 19 and younger. The Plan will pay 50% of covered charges up to a maximum benefit of \$1,500.00 per lifetime. Benefits under this provision are in addition to the benefits set forth under Dental Benefits - Option I or Dental Benefits - Option II. Benefits under this provision are also subject to the limitations as set forth above for Dental Benefits and are also subject to all General Plan Exclusions and Limitations.

Vision Care Benefits

When you or your Dependent incurs expense for vision care, the Plan will pay those expenses up to the maximum amount shown in the Schedule of Benefits and as described in this section. There is **no deductible** required by the Plan before Vision Care Benefits become payable.

Vision Care Benefit:

Employee or Spouse; Each (No Deductible Required).....	\$200.00
.....	Benefit payable once in a 24 month period
Dependent Child; Each (No Deductible Required)	\$150.00
.....	Benefit payable once every calendar year period

The Maximum Amount: The Maximum Amount for all services or supplies considered Covered Expense under the Vision Care Benefits is shown above. Benefits not used in a prior year cannot be carried forward to increase the maximum amount for the next calendar year.

Covered Expenses: Services or supplies must be provided by an Optician, Optometrist, or Ophthalmologist to be considered Covered Expenses. The eye examination to determine what correction may be required and the fitting of any necessary corrective materials (lenses and frames). Services or supplies must be provided by an Optician, Optometrist, or Ophthalmologist to be considered Covered Expenses.

Vision Examination:

The Eligible Person is entitled to one complete vision examination each benefit period (Employee or Spouse each 24 month period and dependent child each calendar year period), including vision screening and vision analysis.

A vision screening includes:

1. A check of the principle vision functions; and
2. Determination of vision ability and condition.

When the vision screening indicates it is necessary, a vision analysis may be done. Vision analysis includes:

1. Complete case history;
2. Measuring and recording of visual acuity, corrected and uncorrected;
3. Examination of fundus, media, crystalline lens, optic disc, and pupil reflex for pathology, anomalies or injury, corneal curvature measurements, retinoscopy;
4. Fusion determination, distance and near, subjective determination, distance and near, stereopsis determination, distance and near;
5. Color discrimination and amplitude of accommodation; and
6. Analysis of findings, lens prescription (if needed), measuring and recording of visual acuity, distance and near, with new prescription if required.

Lenses and Frames:

1. Professional advice on frame selection;
2. Facial measurements, and preparation of specifications for optical laboratory and verifying and fitting of prescription glasses; and
3. Re-evaluation and progress report after fitting new prescription and subsequent servicing.

Limitations:

Vision Care Benefits are not payable for:

1. Examinations or materials more frequently than specifically provided.
2. Lenses, frames or contact lenses which are lost or broken except at the normal intervals when benefits are available.
3. Safety lenses or goggles.
4. Special procedures such as orthoptics, vision training, or aniseikonia.
5. Non-prescription sunglasses.
6. Services, treatment or supplies related to medical or surgical treatment of the eyes.
7. Services, treatment or supplies which are rendered or furnished before the date a person becomes initially eligible or after the date a person's eligibility terminates.

Vision Care Benefits are also subject to all General Plan Exclusions and Limitations.

Prescription Drug Benefits

The Plan provides coverage for a wide range of Prescription Drugs through its Prescription Drug Pharmacy Vendor, NMHC. You will receive a separate identification card for prescription drug benefits and you may call **NMHC's** Customer service line at **(888) 354-0090** regarding any questions about the coverage of your Prescription Drug benefits.

The Prescription Drug benefits are subject to some exclusions and limitations and are subject to the following copays:

Retail Co-pays: (thirty day supply purchased at retail pharmacy)

Generic	the greater of \$10.00 or 10% of cost
Brand	the greater of \$20.00 or 20% of cost
Brand with generic equivalent available	the greater of \$30.00 or 30% of cost

Mail Order Co-pays: (ninety day supply purchased through NMHC's mail order pharmacy)

Generic	the greater of \$20.00 or 10% of cost
Brand	the greater of \$40.00 or 20% of cost
Brand with generic equivalent available	the greater of \$60.00 or 30% of cost

DEATH BENEFITS

If you die from any cause, a Death Benefit is payable in the amount specified in the Schedule of Benefits. The Fund Office must be provided with acceptable proof of death on forms provided by the Trustees.

Death Benefits

Employee Only (under age 70)	\$10,000.00
Employee Only (age 70 and older)	\$ 1,000.00

Beneficiary: The Death Benefit will be paid to the living in the following order:

1. Spouse;
2. Children, including legally adopted children;
3. Parents;
4. Brothers and sisters; or
5. Executor or administrator of the Employee's estate.

If two or more persons are entitled to the Death Benefit, they will share equally.

NOTE: Death benefits are not available to retired participants. Death benefits are reduced to \$1,000.00 for Employees aged 70 and older.

Notice of Claim: Written notice of the death of an Employee whose coverage has been continued under this provision must be given to the Fund Office within twelve (12) months of the date of death. If written notice is not given within such 12 month period, the Plan will not be liable for any payment on account of that death.

Accidental Death and Dismemberment Benefits (Employees Only)

If you lose a limb or an eye, or if you die from a bodily injury the Plan will pay benefits up to the Principal Sum in the Schedule of Benefits provided:

1. The injury was caused solely by an accident occurring while covered; and
2. The loss is directly related to the accident and is independent of all other causes; and
3. The loss occurs within 180 days after the accident.

Accidental Death and Dismemberment Benefits:

Principal sum, Employee Only (under age 70 only) (see schedule).....\$ 1,000.00

The amount of Benefit payable is based on the following:

Life.....	The Principal Sum
Both hands	The Principal Sum
Both feet	The Principal Sum
Both eyes	The Principal Sum
One hand and one foot.....	The Principal Sum
One hand and one eye.....	The Principal Sum
One foot and one eye.....	The Principal Sum
One hand.....	One-half the Principal Sum
One foot.....	One-half the Principal Sum
One eye.....	One-half the Principal Sum

The payments will be made directly to you if living, otherwise to your Beneficiary.

“Loss” with reference to hand or foot means complete severance through or above the wrist or ankle joint and with reference to eye means the irrecoverable loss of the entire sight thereof.

NOTE: Accidental Death and Dismemberment benefits are not available to retired participants. Accidental Death and Dismemberment benefits are not available to Employees age 70 and older.

Limitations:

Benefits will be paid only for the greatest of the above losses if more than one loss results from any one accident.

Benefits **are not** payable for loss due to:

1. Bodily disease or mental infirmity (including medical or surgical treatment thereof);
2. Ptomaine or bacterial infections, except only septic infection on and through a visible wound accidentally sustained;
3. Alcohol, drug or substance abuse;
4. War, act of war, riot or duty in the armed forces;
5. Medical or surgical treatment not made necessary by injury covered under the Plan;
6. Committing an assault or a felony;
7. Self-destruction or injury and/or attempted self-destruction or injury while sane or insane;
8. Medical or surgical treatment or diagnosis;
9. Travel or flight in or descent from any species of aircraft if the eligible person is a student pilot or member of the crew, or if you are a passenger on:
 - a. any civilian aircraft not having a current and valid airworthiness certificate, or piloted by a person who does not then hold a valid and current certificate of competency of a rating authorizing him to pilot such aircraft; or
 - b. any type of aircraft operated by any military authority of the United States, or by any duly constituted governmental authority of any country recognized by the United States Government while in the course of any training maneuvers of any armed forces;
10. Riding, driving or testing of a vehicle used in a speed contest, or participation in the sport of parachute jumping.

SHORT TERM DISABILITY BENEFITS **(Employees Only)**

This benefit applies when an Employee has a Total Disability that meets all of these tests:

1. Total Disability must occur while the Employee is eligible for benefits under this plan.
2. Total Disability must occur while Employee is either actively employed under a collective bargaining agreement with a participating employer in this plan or actively employed by a participating employer as a non-bargaining unit employee and Employee must not be in layoff status.
3. Total Disability must be continuously treated by a Physician. (A chiropractor is not considered a physician for the purpose of disability benefits.) No benefits are payable for any period of time for which the Employee is **not** under the regular care and attendance of a physician.
4. Total Disability is due to an Injury or Sickness that, in either case, is non-occupational -- that is, not arising from work for wage, profit or barter.
5. Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employee's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

The Fund shall reserve the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Employer's choice. Failure to provide requested Physicians' statements will result in termination of benefits. Employees are responsible for providing the following information in a clearly understandable format:

History regarding when symptoms first appeared or accident happened;

- Diagnosis;
- Dates of treatment;
- Nature of treatment;
- Progress;
- Prognosis;
- Suitability for rehabilitation;
- Physician's signature and tax I.D. number.

Additional information may be required based upon the individual Illness or Injury.

BENEFIT PAYMENT

Benefits will be paid for a Total Disability at the rate of a Weekly Benefit of \$300.00 per week for a maximum period of 15 weeks per disability. Benefits provided under this provision are not assignable. Total Disability benefits are payable only during periods in which the Employee is covered under this plan and shall cease on the date of the Employee's termination date of coverage under this plan.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. Benefits are payable only for a maximum of 15 weeks for any one disability arising from the same or related causes. Upon termination of disability new periods due to different causes must be separated by return to Active Work for at least one day. Disability benefits commence on the 1st day following the date of an injury and commence on the 6th day following the date of commencement of illness.

HEALTH REIMBURSEMENT ACCOUNT **(Employees Only)**

TYPE OF PLAN

This is an IRC section 105 Trust Plan which is established for the sole purpose of allowing for Eligible Participants to be reimbursed for Eligible Health Expense(s) as allowable under the Plan. Contributions are made by Employers under the terms of a Collective Bargaining Agreement to the Plan from which Eligible Participants may seek reimbursement for eligible medical expenses. Amounts not used in a plan year may be carried over to the following plan year(s). This Plan is intended to be in full compliance with the provisions of Section 105 of the Internal Revenue Code.

ELIGIBILITY TO PARTICIPATE IN THE HEALTH REIMBURSEMENT PLAN

An Eligible individual and his or her eligible dependents becomes an Eligible Participant under the Plan on the first day of the third calendar month following the date that contributions have been received by the Plan from a contributing employer on behalf of a participant.

CONDITIONS FOR PARTICIPATION IN THE HEALTH REIMBURSEMENT PLAN

Your Eligibility to Participate in the Plan is conditioned on the following:

1. You must have been an Employee of a Contributing Employer and have been covered under the terms of a collective bargaining agreement providing for coverage under this Plan.
2. Your observance of all of the Plan's rules and regulations.
3. You must agree to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan; and
4. You must submit to the Claims Administrator all reports, bills, and other information that the Claims Administrator may reasonably require.

The Eligibility of your Eligible Dependents under the Plan is conditioned on the following:

1. They must be an Eligible Dependent of a Participant under the Plan.
2. Observance of all of the Plan's rules and regulations.
3. They must agree to inquiries by the Claims Administrator with respect to any physician, hospital, or other provider of medical care or other services covered by this Plan; and
4. They must submit to the Claims Administrator all reports, bills, and other information that the Claims Administrator may reasonably require.
5. Their determination as an Eligible Dependent must be established by submission of such information and documentation as the Claims Administrator deems necessary, in the sole discretion of the Claims Administrator, for the proper determination of eligibility.

BENEFITS PROVIDED UNDER THE HEALTH REIMBURSEMENT PLAN

This Plan may be used by the Participant or the Participant's Eligible Dependents for the reimbursement of Eligible Medical Expenses incurred on or after the date you or your Eligible Dependents become Eligible under the Plan. Eligible Expenses can include deductibles, co-payments, co-insurance, self payments, and COBRA continuation coverage payments for terminated Participants.

Under no circumstance will the Plan reimburse expenses under this Plan if those expenses are covered by any other health plan or accident plan or any other type of insurance covering you, your spouse, or any Dependent or if reimbursement for such expense may be available from another source.

CLAIMS FOR BENEFITS – RULES FOR REIMBURSEMENT

1. This Plan may only be used for reimbursement for Eligible Medical Expenses which are incurred on or after the date of your or your Eligible Dependent's Eligibility under the Plan. All claims must be submitted on properly completed forms provided by the Plan and must be submitted within 18 months of incurring the expense. For example you commence working for a contributing Employer (under the terms of a collective bargaining agreement requiring contributions to this Plan) on December 31, 2005 and the Plan commences receiving contributions on your behalf on February 20, 2006, you would be eligible for reimbursement for Eligible Medical Expenses incurred on or after the first day of the third full month following the receipt of contributions on your behalf, and in this example July 1, 2006. Expenses incurred on or before that date are not eligible for reimbursement under the Plan.

2. Application of HRA benefits to self pay. In the event that you are subject to loss of eligibility under the terms of the Plan due to a lack of sufficient hours and your HRA balance is sufficient to prevent a loss of eligibility the HRA will be automatically utilized to prevent your loss of eligibility and you will be notified of its use. In the event that your HRA is insufficient to maintain eligibility you will be notified that a self pay is due and you may use your HRA balance to reduce the self pay required.

3. Your right to benefits under this Plan will terminate on the earlier of: 1) the date on which the balance of the Participant's Account in the Plan reaches zero if the Participant is no longer covered under the terms of a collective bargaining agreement requiring contributions to the Plan; or 2) if in the event contribution continuation is elected under COBRA, the date:

- a) that the COBRA continuation eligibility period ends; or
- b) that required COBRA continuation payments are not received when due.

4. An Expense is incurred on the date when medical care is provided giving rise to the Eligible Medical Expense or, in the instance of the purchase of an Eligible Medical Expense, the date of the actual purchase of the Eligible Medical Expense. The date of billing or payment is not relevant.

5. Making a Claim for Reimbursement Benefits: You have eighteen (18) months from and after the incurring of an Eligible Medical Expense to have received by the Claims Administrator a properly completed claim. Eligible Medical Expenses that are incurred prior to the date a Dependent ceases to be an Eligible Dependent may be submitted for reimbursement from available funds within eighteen (18) months of the date the Eligible Medical Expenses were incurred.

Reimbursement or Payment will only be made if you deliver a properly completed claim form to the Claims Administrator. The claim form shall at minimum provide the following information:

1. The name of the individual on whose behalf Eligible Health Expenses have been incurred;
2. The nature of the Eligible Health Expenses incurred;
3. The amount of the reimbursement or payment sought;
4. A statement that such Eligible Health Expenses are not covered by any other health plan or accident plan or any other type of plan or insurance covering you, your spouse, or any Dependent and that no reimbursement for such expense is available from any other source.
5. The Claims Administrator may require such other information to satisfy the Claims Administrator that the claim is an Eligible Health Expense under the Plan or if such Eligible Health Expense is for a Dependant that such Dependant is an Eligible Dependent under the Plan.

You must attach to the properly completed claim form a copy of your bill or receipt or other satisfactory documentation of the 1) amount of the expense, and 2) the date the expense was incurred. You must also (on the claim form) certify that each expense is an Eligible Health Expense under the Plan, that such expense has not previously been submitted for reimbursement or payment, and that such expense is not reimbursable from any other source.

- Claims for OTC (over-the-counter) medications must include store cash register receipts on which the name of the product has been imprinted by the cash register. Non-imprinted, or hand-annotated cash

register receipts will not be accepted. It is your responsibility to purchase these products at stores that properly document the name of the product purchased. You may only claim OTC products that are used for yourself and your Eligible Dependents.

- For all other types of claims you must enclose an itemized copy of the bill stating the provider's name and address, patient name, and date of service or a copy of the Explanation of Benefits of another Plan. **Collection notices and bills indicating only a balance due are not acceptable. (Cash register receipts from providers are also NOT acceptable.)**
- **The minimum amount requested should be \$100.00 unless you have accumulated less than \$100 in a year.**
- **You have eighteen months from the date of service to submit for reimbursement.**
- **If you do not have enough in your account, the Fund Office will pay what is in the account, and you can resubmit the unpaid balance at a later date.**

All properly submitted and completed claims will after proper review, processing and approval be reimbursed or paid as directed. Claims which are not properly submitted will be denied pending resubmission in proper and complete form. All claims denied pending resubmission are denied in total if resubmission in proper and complete form is not received within twelve (12) months after notice of denial is provided to the claimant at the claimants last known address on the records of the Plan.

Benefits under the Plan will always be limited to a maximum of the amount in the Participant's Account. No claims will be paid that exceed the balance of the Participant's Account. Any claim reimbursed or paid in excess of the balance of the Participant's Account balance will be the responsibility of the Participant to reimburse to the Plan.

If you become terminated from participation in the Plan, any funds remaining in your account will be available for reimbursement as allowed under the Plan. However, upon your termination in the Plan and upon your having been terminated for a period exceeding 12 months an administrative fee of \$25.00 per eligibility quarter will be assessed from your HRA account balance.

EXPENSES WHICH MAY BE REIMBURSED

The HRA established by the Board of Trustees of the Iowa Laborers District Council Health and Welfare Trust can be used by you for reimbursement of out of pocket costs for the following expenses:

- Deductibles and co-payments not covered under the Health and Welfare Fund (and not otherwise covered by other insurance or benefits)
- Medical, Dental, or Vision expenses which are in excess of payments or reimbursements under the Health and Welfare Fund (and not otherwise covered by other insurance or benefits)
- Wellness Exams
- Immunizations
- Lasik surgery
- Hearing Aids
- Birth control pills
- Fertility enhancement
- Psychiatric care
- Smoking cessation programs
- Medically supervised weight loss programs (but not for food or supplements)
- Acupuncture
- Special telephone and television equipment for hearing impaired persons
- Guide dogs for blind or deaf persons
- Subject to special IRS rules:
 - Certain costs of modifying the home or car of a disabled person
 - Certain lodging expenses while accompanying a patient
 - Certain transportation expenses for medical treatment

- Qualified special schooling expenses for mentally impaired or physically disabled persons
- Certain over-the-counter drugs as follows:

Allergy medications
 Antibiotic ointments
 Antacids
 Nicotine medications
 Sleep aids

Cough drops or throat lozenges
 Calamine lotion
 First aid creams
 Pain relievers
 Hemorrhoid medications

Anti-diarrhea medicine
 Cold medicine
 Motion sickness pills
 Sinus medications & nasal sprays
 Wart removal medications

EXCLUDED EXPENSES

You may not use your HRA for any of the following:

- Cosmetic surgery and treatment
- Health club memberships
- Child and elder care
- Household help
- Electrolysis
- Non-prescription drugs, medicines and vitamins (except as specifically listed above)
- Premiums for long-term care insurance
- Expenses for which you have been reimbursed by any other source (or which have been covered by any other source or which are provided to you or the patient free of charge)



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C O V E R A G E M A N U A L

AllianceSelectSM

Iowa Laborers District Council Health and Welfare Trust

NOTICE

This group health plan is sponsored and funded by your employer or group sponsor. Your employer or group sponsor has a financial arrangement with Wellmark under which your employer or group sponsor is solely responsible for claim payment amounts for covered 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.

Form Number: Wellmark IA Grp

Group Effective Date: 1/1/2008
Print Date: 2/25/2008
Coverage Code: N7H
Version: 1/08

Contents

About This Coverage Manual.....	1
1. What You Pay	3
Payment Summary.....	3
Payment Details	3
2. At a Glance - Covered and Not Covered	7
3. Details - Covered and Not Covered	11
4. General Conditions of Coverage, Exclusions, and Limitations.....	23
Conditions of Coverage.....	23
General Exclusions	24
Benefit Limitations.....	25
5. Choosing a Provider.....	27
6. Notification Requirements and Care Coordination	29
7. Factors Affecting What You Pay	33
8. Coverage Eligibility and Effective Date.....	37
Eligible Members.....	37
When Coverage Begins	37
Qualified Medical Child Support Order	37
9. Coverage Changes and Termination.....	39
Coverage Change Events	39
Requirement to Notify Group Sponsor.....	39
Coverage Termination.....	39
Certificate of Creditable Coverage.....	40
Coverage Continuation	40
10. Claims.....	41
When to File a Claim.....	41
How to File a Claim	41
Notification of Decision.....	42
11. Coordination of Benefits	43
Other Coverage.....	43
Claim Filing	43
Rules of Coordination.....	43
Coordination with Medicare	45
12. Appeals.....	47
Right of Appeal.....	47
How to Appeal.....	47
Where to Send Appeal	47
Review of Appeal	47
Decision on Appeal	47
Legal Action	48
13. Your Rights Under ERISA	49
14. General Provisions	53
Contract.....	53
Interpreting this Coverage Manual.....	53

Authority to Terminate, Amend, or Modify	53
Authorized Group Health Plan Changes.....	53
Authorized Representative.....	53
Release of Information	54
Privacy of Information	54
Member Health Support Services	54
Value Added or Innovative Benefits.....	55
Health Insurance Portability and Accountability Act of 1996	55
Nonassignment	57
Governing Law	57
Legal Action	57
Medicaid Enrollment.....	57
Subrogation.....	57
Workers' Compensation.....	59
Payment in Error	60
Notice	60
Glossary.....	61
Index	63

About This Coverage Manual

Contract

This coverage manual describes your rights and responsibilities under your group health plan. You and your covered dependents have the right to request a copy of this coverage manual, at no cost to you, by contacting your employer or group sponsor.

Please note: Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage manual at any time. Any amendment or modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

You should familiarize yourself with the entire manual because it describes your benefits, payment obligations, provider networks, claim processes, and other rights and responsibilities.

Charts

Some sections have charts, which provide a quick reference or summary but are not a complete description of all details about a topic. A particular chart may not describe some significant factors that would help determine your coverage, payments, or other responsibilities. It is important for you to look up details and not to rely only upon a chart. It is also important to follow any references to other parts of the manual. (References tell you to “see” a section or subject heading, such as, “See *Details – Covered and Not Covered*.” References may also include a page number.)

Complete Information

Very often, complete information on a subject requires you to consult more than one section of the manual. For instance, most information on coverage will be found in these sections:

- At a Glance – Covered and Not Covered
- Details – Covered and Not Covered
- General Conditions of Coverage, Exclusions, and Limitations

However, coverage might be affected also by your choice of provider (information in the *Choosing a Provider* section), certain notification requirements if applicable to your group health plan (the *Notification Requirements and Care Coordination* section), and considerations of eligibility or preexisting conditions (the *Coverage Eligibility and Effective Date* section).

Even if a service is listed as covered, benefits might not be available in certain situations, and even if a service is not specifically described as being excluded, it might not be covered.

Read Thoroughly

You can use your group health plan to the best advantage by learning how this document is organized and how sections are related to each other. And whenever you look up a particular topic, follow any references, and read thoroughly.

Your coverage includes many services, treatments, supplies, devices, and drugs. Throughout the coverage manual, the words *services or supplies* refer to any services, treatments, supplies, devices, or drugs, as applicable in the context, that may be used to diagnose or treat a condition.

Questions

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

1. 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 coverage manual, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

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.

Category	You Pay
Deductible	\$250 per person \$750 (maximum) per family*
Chiropractic Office Visit Copayment	\$20 for PPO services.
Emergency Room Copayment	\$200 for PPO services.
Office Visit Copayment	\$20 for PPO services.
Coinsurance	10% for covered services received from PPO providers. 20% for covered services received from participating and nonparticipating providers. 20% for the inpatient and outpatient treatment of mental health conditions and chemical dependency when received from PPO providers. 30% for the inpatient and outpatient treatment of mental health conditions and chemical dependency when received from participating and nonparticipating providers.
Out-of-Pocket Maximum	\$3,000 per person for covered services received from PPO providers. \$6,000 (maximum) per family* for covered services received from PPO providers. \$4,000 per person for covered services received from participating and nonparticipating providers. \$8,000 (maximum) per family* for covered services received from participating and nonparticipating providers.
Lifetime Benefits Maximum	\$2,000,000 per person

*Family amounts are reached from amounts accumulated on behalf of any combination of family members.

Payment Details

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 family members.

Once you meet the deductible, then coinsurance applies.

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.

Chiropractic Office Visit Copayment.

The chiropractic office visit copayment:

- applies to covered office services received from PPO chiropractors.
- is taken once per practitioner per date of service.

Related x-ray and laboratory services are subject to deductible and coinsurance and not this copayment.

Emergency Room Copayment.

The emergency room copayment:

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

Office Visit Copayment.

The office visit copayment:

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

Related office 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 33. Coinsurance amounts apply after you meet the deductible and any applicable copayments.

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.

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

Out-of-pocket maximum amounts you pay to PPO, participating, or nonparticipating providers apply toward meeting both the PPO and participating/nonparticipating out-of-pocket maximum amounts.

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 23.
- Coinsurance amounts for the inpatient and outpatient treatment of chemical dependency.
- Copayments.

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

Lifetime Benefits Maximum

This is the maximum payment amount each member is eligible to receive for covered services in his or her lifetime.

Lifetime benefits maximum amounts are accumulated from claim payment amounts under this medical benefits plan and prior medical benefits plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Waived Payment Obligations

Some payment obligations are waived for the following covered services.

Covered Service	Payment Obligation Waived
Hearing aids and hearing exams.	Deductible Coinsurance
Human Papillomavirus (HPV) immunizations.	Deductible Coinsurance Copayment
Newborn's initial hospitalization, when considered normal newborn care – facility and practitioner services.	Deductible
Preventive physical examination and related services.	Deductible Coinsurance
Services subject to chiropractic office visit copayment amounts.	Deductible Coinsurance
Services subject to office visit copayment amounts.	Deductible Coinsurance
Well-child care.	Deductible

2. At a Glance - Covered and Not Covered

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 coverage manual. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 11. To fully understand which services are covered and which are not, you must become familiar with this entire coverage manual. 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.

Service Maximum. This column lists maximum benefit amounts that each member is eligible to receive per covered service, benefit year, or lifetime. Service maximums that apply per benefit year or per lifetime are reached from claim payment amounts 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	Service Maximum
Acupuncture Treatment		⊖	11	
Allergy Testing and Treatment	●		11	
Ambulance Services	●		11	
Anesthesia	●		11	
Blood Administration	●		11	
Chemical Dependency Treatment	●		11	\$10,000 for inpatient and outpatient treatment per lifetime.
Chemotherapy and Radiation Therapy	●		11	
Cosmetic Services		⊖	11	
Counseling Services		⊖	12	
Dental Treatment for Accidental Injury	●		12	
Dialysis	●		12	

Category	Covered	Not Covered	See Page	Service Maximum
Education Services for Diabetes	●		12	10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour annually.
Emergency Services	●		12	
Fertility and Infertility Services	●		13	
Genetic Testing	●		13	
Hearing Services	●		13	\$600 for hearing aids and one routine hearing examination every 36 months.
Home Health Services	●		13	
Home/Durable Medical Equipment	●		14	
Hospice Services	●		15	15 days of inpatient hospice respite care per lifetime. 15 days of outpatient hospice respite care per lifetime. Please note: Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		15	
Illness or Injury Services	●		15	
Inhalation Therapy	●		16	
Maternity Services	●		16	
Medical and Surgical Supplies	●		16	
Mental Health Services	●		16	12 days for inpatient treatment per benefit year. 24 visits for outpatient treatment per benefit year.
Morbid Obesity Treatment	●		17	\$35,000 for weight reduction surgery and related services per lifetime.
Motor Vehicles		⊖	17	
Musculoskeletal Treatment	●		17	
Nonmedical Services		⊖	18	
Occupational Therapy	●		18	
Orthotics		⊖	18	
Physical Therapy	●		18	
Physicians and Practitioners			18	
Advanced Registered Nurse Practitioners	●		18	
Chiropractors	●		18	\$700 per benefit year.
Doctors of Osteopathy	●		18	
Licensed Independent Social Workers	●		18	
Medical Doctors	●		18	

Category	Covered	Not Covered	See Page	Service Maximum
Occupational Therapists	●		18	
Optometrists	●		18	
Oral Surgeons	●		18	
Physical Therapists	●		18	
Physician Assistants	●		18	
Podiatrists	●		18	
Psychologists	●		18	
Speech Pathologists	●		18	
Prescription Drugs	●		19	
Preventive Care	●		19	<p>Well-child care until the child reaches age three. \$750 for well-child care per benefit year. One routine mammogram per benefit year. \$500 for routine physical examinations and related preventive services per benefit year. This limit includes:</p> <ul style="list-style-type: none"> ■ Immunizations, except for Human Papillomavirus (HPV) immunizations and those related to well-child care. ■ One routine gynecological examination per benefit year. ■ Routine Pap smears. <p>This limit does not include:</p> <ul style="list-style-type: none"> ■ Colonoscopies. ■ Human Papillomavirus (HPV) immunizations. ■ Mammograms. ■ Well-child care.
Prosthetic Appliances	●		20	
Reconstructive Surgery	●		20	
Self Help Programs		⊖	20	
Sleep Apnea Treatment	●		20	
Speech Therapy	●		20	
Surgery	●		21	
Temporomandibular Joint Disorder (TMD)	●		21	
Transplants	●		21	\$10,000 per operation for costs associated with a member's transportation in an ambulance to a transplant center.
Travel or Lodging Costs		⊖	21	
Vision Services (related to an illness or injury)	●		21	
Wigs or Hair Pieces		⊖	21	
X-ray and Laboratory Services	●		21	

3. 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 coverage manual. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 23. If a service or supply is not specifically listed, do not assume it is covered.

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional air and 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:

- No other method of transportation is appropriate.
- 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 or nursing facility with adequate facilities to treat your medical condition.

See Also:

Transplants later in this section.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

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

Blood Administration

Covered: Blood administration.

Not Covered: Blood. This exclusion does not apply to members with hemophilia.

Chemical Dependency Treatment

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

Service Maximum:

- **\$10,000** for inpatient and outpatient treatment per lifetime.

Not Covered:

- Residential facility services.

See Also:

Hospitals and Facilities later in this section.

Chemotherapy and Radiation Therapy

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

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling Services

Not Covered: Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.

See Also:

Genetic Testing later in this section.

Mental Health Services later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when:
 - Treatment is completed within six months of the injury.
- 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.

- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, cast restorations, dentures and bridges, and orthodontic services.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration).

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

Covered: Inpatient and outpatient training and education for the self-management of all types of diabetes mellitus.

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.

Service Maximum:

- **10 hours** of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour annually.

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. However, because we do not have contracts with nonparticipating 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.

See Also:

Nonparticipating providers, page 34.

Fertility and Infertility Services

Covered:

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

Not Covered:

- Abortion that is voluntary.
- 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 of sperm, oocytes, or embryos; surrogate parent services.
- Infertility diagnosis and treatment.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

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.

See Also:

Prior Approval, page 30.

Hearing Services

Covered:

- Routine hearing examinations.
- Hearing aids.

Service Maximum:

- **\$600** for hearing aids and **one** routine hearing examination every 36 months.

Not Covered:

- Hearing examinations received from an audiologist unless the audiologist is employed by, and your treatment is billed by, an M.D. or D.O.

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 our case manager 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 care is prescribed by a physician and approved by a Wellmark case manager.

The following are covered services and supplies:

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

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. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. Custodial care is not included in this benefit. Home skilled nursing is limited to services that are intermittent and do not exceed two hours per visit. Home skilled nursing will be coordinated by a case manager.

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.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Appliances and Braces.

Speech Therapy.

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 sanitarium care or rest cures.

See Also:

Case Management, page 31.

Precertification, page 29.

Home/Durable Medical Equipment

Covered: Equipment that meets all of the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Used to serve a medical purpose.

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 later in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Prior Approval, page 30.

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. Hospice care must be precertified.

Service Maximum:

- **15 days** of inpatient hospice respite care per lifetime.
- **15 days** of outpatient hospice respite care per lifetime.
- Not more than **five days** of hospice respite care at a time.

See Also:

Precertification, page 29.

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.

Chemical Dependency Treatment Facility. This type of facility provides treatment of chemical dependency and

must be licensed and approved by Wellmark.

Community Mental Health Center.

This type of facility provides outpatient treatment of mental health conditions and must be licensed and approved by Wellmark.

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. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

Not Covered:

- Residential Treatment Facility. This type of facility provides treatment for severe, persistent, or chronic mental health conditions or chemical dependency that meets all of the following criteria:
 - Treatment is provided in a 24-hour residential setting.
 - Treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision.
 - Treatment includes training in basic skills such as social skills and activities of daily living.
 - Treatment does not require daily supervision of a physician.

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.

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.

See Also:

Precertification, page 29.

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.

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.

If the inpatient hospital stay is shorter, coverage includes a 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 39.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.

Not Covered:

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.
- Insulin syringes or supplies.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Mental Health Services

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

provide mental health services on an outpatient basis.

Coverage includes diagnosis and treatment of these biologically based mental illnesses:

- Schizophrenia.
- Bipolar disorders.
- Major depressive disorders.
- Schizo-affective disorders.
- Obsessive-compulsive disorders.
- Pervasive developmental disorders.
- Autistic disorders.

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

- The disorder is listed only as a mental health condition in the most current “International Classification of Diseases, Ninth Revision, Clinical Modification” (ICD-9-CM) and not dually listed elsewhere in the ICD-9-CM.
- The disorder is not a chemical dependency condition.

Service Maximum:

- **12 days** for inpatient treatment per benefit year.
- **24 visits** for outpatient treatment per benefit year.

Not Covered:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nicotine dependence.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual identification or gender disorders.
- Residential facility services.

See Also:

Hospitals and Facilities earlier in this section.

Morbid Obesity Treatment

Covered: Weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this coverage manual, or call the toll-free Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the toll-free Customer Service number or go to www.wellmark.com.

Service Maximum:

- **\$35,000** for weight reduction surgery and related services per lifetime.

Not Covered:

- 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:

Prior Approval, page 30.

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.

Not Covered: Massage therapy.

Nonmedical 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, and educational or recreational therapy or services or supplies that are nonmedical.

Occupational Therapy

Covered: Services are covered, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Not Covered:

- Occupational therapy supplies.
- Occupational therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

Orthotics

Not Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such foot devices, supports, or shoes.

See Also:

Home/Durable Medical Equipment earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

Prosthetic Appliances later in this section.

Physical Therapy

Covered.

Not Covered: Physical therapy provided as an inpatient in the absence of a separate medical condition that requires hospitalization.

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.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

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.

Service Maximum:

- \$700 for chiropractic services per benefit year.

Not Covered:

- Athletic Trainers.
- Audiologists.

See Also:

Choosing a Provider, page 27.

Prescription Drugs

Covered:

- When you are an inpatient or outpatient of a facility.

Additional prescription drugs and medicines covered under this medical benefits plan include:

Drugs and Biologicals. Drugs and biologicals approved by the Food and Drug Administration. This includes such supplies as globulin, 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).

Not Covered:

- Contraceptive devices.
- Contraceptives absorbed through the skin.
- Glucose strips.
- Implanted contraceptives.
- Injected contraceptives.
- Insulin.
- Oral contraceptives.
- Prescription drugs and devices used to treat nicotine dependence, including related medical evaluations, psychotherapy, and x-ray and lab services.
- Prescription drugs other than as stated earlier in this section.

See Also:

Blood Administration earlier in this section.

Preventive Care

Covered:

- Physical examinations and related preventive services such as:
 - Gynecological examinations.
 - Immunizations.
 - Mammograms.
 - Pap smears.
- Normal newborn care (physician services provided to a baby during the mother's initial hospitalization).
- Well-child care including immunizations.

Service Maximum:

- Well-child care until the child reaches age three.
- **\$750** for well-child care per benefit year.
- **One** routine mammogram per benefit year.
- **\$500** for routine physical examinations and related preventive services per benefit year. This limit includes:
 - Immunizations, except for Human Papillomavirus (HPV) immunizations and those related to well-child care.
 - **One** routine gynecological examination per benefit year.
 - Routine Pap smears.
 This limit does not include:
 - Colonoscopies.
 - Human Papillomavirus (HPV) immunizations.
 - Mammograms.
 - Well-child care.

Not Covered:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Appliances

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 appliances and 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:

- Devices such as eyeglasses, orthopedic shoes, arch supports, or examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 25.

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:

Prior Approval, page 30.

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.

See Also:

Prior Approval, page 30.

Speech Therapy

Covered: Rehabilitative speech therapy treatment.

Not Covered:

- Speech therapy services not coordinated through home health services when the services are received through a home health agency.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

See Also:

Prior Approval, page 30.

Surgery

Covered. This includes the following:

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

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: 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.

Transplants are subject to Case 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 this medical benefits plan.

Service Maximum:

- **\$10,000** per operation for costs associated with a member's transportation in an ambulance to a transplant center.

Not Covered:

- 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 and ambulance services.

See Also:

Prior Approval, page 30.

Case Management, page 31.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Vision examinations but only when related to an illness or injury.

Not Covered:

- Surgery to correct a refractive error (i.e. when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Eye exercises.
- Prescribing of corrective lenses.
- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

Wigs or Hair Pieces

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.

4. 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. 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 is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
 - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
 - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
 - Any other relevant factors.
- 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 a nonparticipating 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 that 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 37.

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, 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.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association, including whether a service, supply, device, 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 settings.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual 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. Copies of the evaluation criteria and the reference manual information for a specific service, supply, device, or drug are available upon request.

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

- You receive the services from a nonparticipating 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.

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.

Nonmedical Services

You are not covered for telephone consultations, charges for missed appointments, charges for completion of any form, or charges for information.

Personal Convenience Items

You are not covered for items used for your personal convenience, such as:

- 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, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

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).

Covered by Other Programs or Laws

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

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health plan, you would not be charged.

- 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 that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

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

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 service maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 11.
- If you receive total benefits in an amount that reaches a lifetime benefits maximum, you are no longer eligible for benefits under this group health plan. See *Lifetime Benefits Maximum*, page 5, and *At a Glance–Covered and Not Covered*, page 7.
- If you do not obtain precertification for medical services, benefits can be

reduced or denied. You are responsible for these benefit reductions only if you are responsible (not your provider) for notification. A PPO provider will handle notification requirements for you. See *Notification Requirements and Care Coordination*, page 29.

- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 27, and *Factors Affecting What You Pay*, page 33. Examples of charges that depend on the type of provider include but are not limited to:
 - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from a nonparticipating provider.

5. Choosing a Provider

This medical benefits plan is called Alliance Select.

It relies on a preferred provider organization (PPO) network, which consists of providers that participate directly with Alliance Select 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.

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, but not with a PPO.

Other providers are considered nonparticipating, and you will usually pay the most for services you receive from them.

See *What You Pay*, page 3 and *Factors Affecting What You Pay*, page 33.

To determine if a provider participates with this medical benefits plan, ask your provider, visit our Web site at www.wellmark.com, or www.bcbs.com,

refer to your provider directory (a separate document that's available, without charge), or call **800-810-BLUE**.

For types of providers that may be covered under this medical benefits plan, see *Hospitals and Facilities*, page 15 and *Physicians and Practitioners*, page 18.

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 nonparticipating 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 do not participate with Alliance Select, although some pharmacies may still file claims for you electronically.

Provider Comparison Chart	PPO	Participating	Nonparticipating
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	Yes	No
Minimizes your payment obligations. See <i>What You Pay</i> , 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*	No	No

*If you visit a PPO 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

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.

BlueCard Program. We participate with other Blue Cross and Blue Shield Plans in a national program called the BlueCard Program. This program ensures that members of any Blue Plan have access to the advantages of PPO providers throughout the United States.

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 BlueCard 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.

BlueCard 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 BlueCard 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 health plan payment is sent directly to the providers.

When you receive covered services from BlueCard providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 29.

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 nonparticipating except for services received from providers that participate with BlueCard Worldwide.

6. Notification Requirements and Care Coordination

Many 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.

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 plan 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 47. Also see *Authorized Representative*, page 53.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. This notification requirement is mandatory; however, it does not apply to maternity or emergency services.
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Applies to	Acute Rehabilitation Facilities Home Health Services Home Infusion Therapy Hospice Services Nursing Facilities Facilities Outside Iowa or South Dakota
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Person Responsible	PPO providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for notifying us if: <ul style="list-style-type: none">■ You are admitted to a facility outside Iowa or South Dakota;■ You receive any of the services listed above from a participating or nonparticipating provider.
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Process	When you, instead of your PPO provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: <ul style="list-style-type: none">■ 72 hours in a medically urgent situation;■ 15 days in a non-medically urgent situation.
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Importance	<p>If you choose to obtain any service subject to precertification even though we were unable to certify its medical necessity, you will be responsible for the charges.</p> <p>Even if a service is medically necessary and otherwise covered, without precertification, benefits will be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. See <i>Maximum Allowable Fee</i>, page 35. You are subject to this benefit reduction only if you (instead of your PPO provider) are responsible for notification.</p> <p>Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See <i>What You Pay</i>, page 3.</p>
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Prior Approval

Purpose	<p>Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical plan before you receive services. This notification is recommended.</p>
Applies to	<p>The most common services for which we recommend prior approval include, but are not limited to, the following list. For a complete list of services subject to prior approval, visit www.wellmark.com or call the Customer Service phone number on your ID card.</p> <p>Genetic Testing</p> <p>Home/Durable Medical Equipment</p> <p>Obstructive Sleep Apnea Treatment</p> <p>Reconstructive Surgery</p> <p>Speech Therapy</p> <p>Transplants</p> <p>Weight Reduction Surgery</p>
Person Responsible	<p>PPO providers request prior approval for you. You are responsible for prior approval if you receive the care from a participating or nonparticipating provider.</p>
Process	<p>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.</p> <p>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 by mailing the decision to the most current address on record for both you and your provider within:</p> <ul style="list-style-type: none"> ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation.

Importance	<p>If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and service 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, it may not be covered.</p> <p>Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits plan 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 a new medical benefits plan), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.</p> <p>Note: An admission to a facility outside Iowa or South Dakota to receive a service for which prior approval is recommended is also subject to precertification. See <i>Precertification</i> earlier in this section.</p>
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Continued Stay Review

Purpose	Continued stay review helps determine whether ongoing care is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	<p>Inpatient Facility Admission</p> <p>Home Health Services</p> <p>Home Infusion Therapy</p> <p>Hospice Services</p>
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary.
Importance	<p>Wellmark may require a change in the level or place of service in order to continue providing benefits.</p> <p>If we determine that your current 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.</p>

Case Management

Purpose	Case management is a process of considering alternative treatments for members with severe illnesses or injuries that require costly, long-term care. Depending on the individual circumstances, a hospital may not be the most appropriate setting for treatment.
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Applies to	<p>Examples where case management might be appropriate include but are not limited to:</p> <ul style="list-style-type: none"> Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Home Health Services Pregnancy (high risk) Transplants
Person Responsible	<p>You, your physician, and the health care facility can work with Wellmark's case managers to identify and arrange alternative treatment plans to meet special needs. Wellmark may initiate a request for case management.</p>
Process	<p>Wellmark's case managers try to identify alternative settings or treatment plans, provided costs do not exceed those of an inpatient facility. A benefit program is tailored to the circumstances of the case.</p> <p>Even if a service is not covered or is subject to a specific limitation, Wellmark may waive exclusions or limitations with the agreement of its medical director.</p> <p>If your current level or setting of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified at least 24 hours before benefits end.</p>
Importance	<p>Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.</p>

7. Factors Affecting What You Pay

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

Benefit Year

A benefit year is the same as a calendar year and starts over each January 1. It continues even if you change benefits under the medical benefits plan sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

If you are an inpatient in a covered facility on the date your benefit year renews, your benefit limitations and payment obligations for facility services will also renew and will be based on the amounts in effect on the date you were admitted. However, your payment obligations for practitioner services will be based on the amounts in effect on the day you receive services.

The benefit year is important for calculating:

- Deductible.
- Coinsurance.
- Out-of-pocket maximum.
- Service 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 All Participating and Nonparticipating Providers

Excluding PPO office and independent lab services, coinsurance is calculated using the payment arrangement amount after the following applicable amounts are subtracted from it:

- Deductible.
- Certain copayments.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

PPO Providers' Office and Independent Lab Services

For covered services you receive in the office of PPO practitioners in the Wellmark service area, or independent lab services received from PPO providers in the Wellmark service area, coinsurance is calculated using the amount charged after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Office visit copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

BlueCard PPO 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 payment arrangement or negotiated price that the local Blue Cross or Blue Shield Plan passes on 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 23.

Often, the payment arrangement or negotiated price consists of a simple discount that reflects the actual price paid

by the local Blue Plan. Sometimes, it is an estimated price that factors in expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with the health care provider or a specific group of providers. The payment arrangement or negotiated price may also be charged amounts reduced to reflect an average expected savings with the provider or group of providers. A price that reflects average savings may result in greater variation from the actual price paid than will an estimated price. The payment arrangement or negotiated price may also be adjusted in the future to correct for over- or under-estimates of past prices; however, the amount you pay is considered a final price.

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 amount charged for covered services after the following applicable amounts are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

Statutes in a few states may require the local Blue Plan to use a basis for calculating your payment obligation for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. In such a case, Wellmark would calculate your payment obligation in accordance with the applicable state statute in effect at the time you received your care. For more information, see *BlueCard Program*, page 28.

PPO Providers

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

- The PPO amounts for the following are waived for certain covered services. See *Waived Payment Obligations*, page 5.
 - Deductible.
- The PPO amounts for the following are less than the nonparticipating amounts.
 - Coinsurance.
 - Out-of-Pocket Maximum.
- These providers agree to accept Wellmark's payment arrangements or payment arrangements or negotiated prices of the Blue Cross and 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.

Nonparticipating Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with nonparticipating providers, and they may not accept our payment arrangements. Therefore, when you receive services from nonparticipating providers:

- You are responsible for any difference between the amount charged and our payment for a covered service.
- Wellmark does not make claim payments directly to these providers. You are responsible for ensuring that your provider is paid in full.
- The health plan payment for nonparticipating hospitals, M.D.'s, and D.O.'s in Iowa 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 billed balance you may owe).

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 this medical benefits plan.

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 facility could be different from the covered charge. Regardless of the amount we pay a facility, 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 this health plan and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a service

maximum, benefit year maximum, or lifetime benefits maximum; reductions for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 23.

- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following applicable amounts from the amount charged:
 - Deductible.
 - Coinsurance.
 - Copayment.
 - Amounts representing any general exclusions and conditions.
 - Network savings.

Payment Method for Services

Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. 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.

8. Coverage Eligibility and Effective Date

Eligible Members

You are eligible for coverage if you meet your employer's or group sponsor's eligibility requirements. Also eligible for coverage is an eligible member's spouse.

A dependent child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member or an enrolled spouse:

- A natural child.
- Legally adopted or placed for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child).
- A child for whom you have legal guardianship.
- A stepchild.
- A foster child.
- A natural child a court orders to be covered.

A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

In addition, a dependent child must be unmarried and must be one of the following:

- Under age 19.
- A full-time student under age 25 enrolled in an accredited educational institution. Full-time student status continues during regularly scheduled school vacations and during extended absences for up to four months due to a physical or mental disability.
- Totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 19, or while the child was a full-time student under age 25. In

addition, the child must have had creditable coverage without a break of 63 days or more since turning age 19 or since becoming a full-time student under age 25.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 39.

When Coverage Begins

Coverage begins on the member's effective date. If you have just started a new job, or if a coverage enrollment event allows you to add a new member, ask your employer or group sponsor about your effective date. Services received before the effective date of coverage are not eligible for benefits.

Qualified Medical Child Support Order

If you have a dependent child and you or your spouse's employer or group sponsor receives a Medical Child Support Order recognizing the child's right to enroll in this group health plan or in your spouse's benefits plan, the employer or group sponsor will promptly notify you or your spouse and the dependent that the order has been received. The employer or group sponsor also will inform you or your spouse and the dependent of its procedures for determining whether the order is a Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

A QMCSO specifies information such as:

- Your name and last known mailing address.
- The name and mailing address of the dependent specified in the court order.

- A reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined.
- The period to which the order applies.

A Qualified Medical Child Support Order can not require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

The order and the notice given by the employer or group sponsor will provide additional information, including actions that you and the appropriate insurer must take to determine the dependent's eligibility and procedures for enrollment in the benefits plan, which must be done within specified time limits.

If eligible, the dependent will have the same coverage as you or your spouse do and will be allowed to enroll immediately. You or your spouse's employer or group sponsor will withhold any applicable share of the dependent's health care premiums from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after the insurer receives the QMCSO, your employer or group sponsor must notify us when you become eligible for enrollment. Enrollment of the dependent will commence after you have satisfied the waiting period.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

Your employer or group sponsor may not revoke enrollment or eliminate coverage for a dependent unless the employer or group sponsor receives satisfactory written evidence that:

- The court or administrative order requiring coverage in a group health plan is no longer in effect;
- The dependent's eligibility for or enrollment in a comparable benefits plan that takes effect on or before the date the dependent's enrollment in this group health plan terminates; or
- The employer eliminates dependent health coverage for all employees.

The employer or group sponsor is not required to maintain the dependent's coverage if:

- You or your spouse no longer pay premiums because the employer or group sponsor no longer owes compensation; or
- You or your spouse have terminated employment with the employer and have not elected to continue coverage.

9. Coverage Changes and Termination

Certain events may require or allow you to add or remove persons who are covered by this group health plan.

Coverage Change Events

Coverage Enrollment Events: The following events allow you as well as an affected spouse or eligible child to enroll for coverage. If your employer or group sponsor offers more than one group health plan, the event also allows you to move from one plan option to another.

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA coverage.
- Member, spouse, or dependent loses eligibility for creditable coverage or his or her employer or group sponsor ceases contribution to creditable coverage.
- Spouse loses coverage through his or her employer.

The following events allow you to add only the new dependent resulting from the event:

- Dependent child under age 25 resumes status as a full-time student.
- Addition of a natural child by court order. See *Qualified Medical Child Support Order*, page 37.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

Coverage Removal Events: The following events require you to remove the affected family member from your coverage:

- Completion of a dependent's full-time schooling.
- Death.
- Dependent child who is not a full-time student or permanently disabled reaches age 19.

- Dependent child who is a full-time student reaches age 25.
- Divorce, annulment, or legal separation.
- Marriage of a dependent child.
- Reaching the overall lifetime benefits maximum.
- Medicare eligibility. If you become eligible for Medicare, you must notify your employer or group sponsor immediately. If you are eligible for this group health plan other than as a current employee or a current employee's spouse, your Medicare eligibility may terminate this coverage.

Requirement to Notify Group Sponsor

You must notify your employer or group sponsor within 31 days of an event that changes the coverage status of members. If you do not provide timely notification of an event that requires you to remove an affected family member, your coverage may be terminated.

Coverage Termination

The following events terminate your coverage eligibility.

- You become unemployed when your eligibility is based on employment.
- You become ineligible under your employer's or group sponsor's eligibility requirements for reasons other than unemployment.
- Your employer or group sponsor discontinues or replaces this group health plan.
- We terminate coverage of all similar group health plans by written notice to your employer or group sponsor 90 days prior to termination.

Also see *Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment* later in this section.

When your coverage terminates, check with your employer or group sponsor or call the customer service number on your ID card to verify the coverage termination date.

If you are an inpatient of a hospital or a resident of a nursing facility on the date your coverage eligibility terminates, benefits for inpatient services are limited to the least amount of the following:

- The period of your remaining days of coverage under this medical benefits plan.
- The period ending on the date you are discharged from the facility.
- A period not more than 60 days from the date of termination.

Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or fraudulently misrepresent or conceal a material fact in your application; or
- Your employer or group sponsor commits fraud or intentionally misrepresents a material fact under the terms of this group health plan.
- You or your employer or group sponsor fails to make required payments to us when due, or you fail to pay any applicable amounts you owe.

If your coverage is terminated for fraud, misrepresentation, or the concealment of a material fact, then:

- We may declare this group health plan void.
- Premiums will be retroactively adjusted as if a misrepresented or concealed material fact had been accurately disclosed in your application.
- We will recover any claim payments made.
- We will retain legal rights, including the right to bring a civil action.

Certificate of Creditable Coverage

Wellmark will provide certification of your coverage under this medical benefits plan if:

- This coverage terminates.
- You become eligible for COBRA coverage or coverage continuation under Iowa law.
- You exhaust your COBRA coverage.
- You request certification of your coverage within 24 months after this coverage terminates. See *Notice*, page 60.

Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this group health plan or to convert to another Wellmark health benefits plan pursuant to certain state and federal laws.

COBRA Continuation

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and eligible dependents to continue coverage if it is lost due to a qualifying event, such as employment termination, divorce, or loss of dependent status. You and your eligible dependents will be required to pay for continuation coverage. Other federal or state laws similar to COBRA may apply if COBRA does not. Your employer or group sponsor is required to provide you with additional information on continuation coverage if a qualifying event occurs.

10. Claims

Once you receive medical 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.

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.

Effective April 1, 2008, Wellmark must receive claims within 365 days following the date of service of the claim.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

Forms are available at www.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.

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. Send the claim to:

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue, Station 39
Des Moines, IA 50309-2565

Claims for Services Received Outside the United States. Send the claim to:

BlueCard Worldwide Service Center
P.O. Box 90320
Richmond, VA 23230-9320

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

Notification of Decision

We will send an Explanation of Health Care 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 43.

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. In the case of nonparticipating 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.

11. Coordination of Benefits

Coordination of benefits applies when you have more than one 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 non-medical 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 have a nonparticipating 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. 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 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 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.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

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.

If none of these rules apply to your situation, we will follow the Iowa Insurance Division's Coordination of Benefits guidelines to determine this health plan payment.

Effects on the Benefits of this Plan

When this plan is secondary, we may reduce its benefits so that total benefits paid or provided by all plans during a plan year are

not more than the total allowable expenses. 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.

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.

Coordination with Medicare

Medicare is by law the secondary coverage to group health plans in a variety of situations. The following provisions apply only if you have both Medicare and employer group health coverage under this medical benefits plan and your employer has the required minimum number of employees.

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 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 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 coverage if both of the following are true:

- The beneficiary has 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 covered for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws, which may change from time to time. For more information, contact your employer or the Social Security Administration.

12. Appeals

Right of Appeal

You have the right to one full and fair review in case of a denied or reduced claim, or an adverse decision concerning a pre-service notification requirement. An adverse decision is one that denies or reduces benefits. Pre-service notification requirements are:

- Continued stay in a facility.
- A precertification request.
- A prior approval request.

How to Appeal

You or your authorized representative, if you have designated one, may appeal a reduced or denied benefit by calling the Customer Service number on your ID card or by writing to Wellmark. See *Authorized Representative*, page 53.

Medically Urgent Appeal

For appeals involving a medically urgent situation, you may request an expedited appeal, either orally or in writing.

Non-Medically Urgent Appeal

For appeals that are not medically urgent, you must make your request for a review, in writing, within 180 days from the date you are notified of our adverse decision.

What to Include in Your Appeal

You must submit all relevant information with your initial 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.

If you have difficulty obtaining this information, ask your provider or pharmacist to assist you.

Where to Send Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Appeals/ERISA Review Office
636 Grand Avenue, Station 52
Des Moines, IA 50309-2565

Review of Appeal

Your request for an appeal will be reviewed only once. The review will take into account all information regarding the adverse decision 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 decision.

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. 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 Appeal

The decision on appeal is final. Once a decision on appeal is reached, your right to appeal is exhausted.

Medically Urgent Appeal

For a medically urgent appeal, you will be notified (by telephone, email, fax or another prompt method) of our decision as soon as possible, but no later than 72 hours after your expedited appeal is received. Written

notification will follow within three days of the initial notice.

Non-Medically Urgent Appeal

An appeal of a denied or reduced claim will be decided within 60 days. An appeal of an adverse decision concerning a pre-service notification requirement will be decided within 30 days.

Legal Action

You shall not start legal action against us until you have exhausted the appeal procedure described in this section.

13. Your Rights Under ERISA

Employee Retirement Income Security Act of 1974

Your rights concerning your coverage may be protected by the Employee Retirement Income Security Act of 1974 (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 health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

Receive Information About Your Plan and Benefits

You may examine, without charge, at the plan administrator's office or at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining 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 administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator 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.

Continued Group Health Plan Coverage

You have the right to continue health care coverage for yourself, 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 coverage manual and the documents governing the plan. See *COBRA Continuation*, page 40.

You have the right to reduced or eliminated exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

- You lose coverage under the plan.
- You become entitled to COBRA continuation coverage.
- Your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion period for up to 12 months (up to 18 months for late enrollees) after your enrollment date in the coverage. See *Certificate of Creditable Coverage*, page 40.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of your employee benefits plan. 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.

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.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you

need assistance in obtaining documents from the plan administrator, 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*.

ERISA Information Requirements

Plan Name:	Iowa Laborers District Council Health and Welfare
Plan Sponsor:	The Plan Sponsors are the Trustees of the Iowa Laborers District Council Health and Welfare Trust Fund.
Employer ID Number:	42-0946060
Plan Number:	501
When Plan Year Ends:	October 31
Participants of Plan:	Participants of the Plan are those employees of Participating Employers meeting the eligibility requirements of the Plan.
Plan Administrator and Agent for Service of Legal Process:	Board of Trustees of the Iowa Laborers District Council Health and Welfare Trust Fund 150 1st Avenue NE, Suite 150 Cedar Rapids, IA 52401 Trustees of this Fund are: Management Trustees: Denis Reed, Secretary Brett Nuckolls Susan Kartman Union Trustees: Steve Piper, Chairman William Gerhard Leonard Leo Gary Crees John Penn
How Plan Costs Are Funded:	All benefits payable under this Plan are self-funded and paid directly from the accumulated assets of the Trust Fund.
Type of Plan:	Group Health Plan
Type of Administration:	Self-Funded
Benefits Administered by:	Wellmark Blue Cross and Blue Shield of Iowa 636 Grand Avenue Des Moines, IA 50309-2565

If this plan is maintained by two or more employers, you may write to the plan administrator for a complete list of the plan sponsors.

This group benefits plan is maintained pursuant to a collective bargaining agreement. A copy of such agreement may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries, as required by §§2520.104b-1 and 2520.104b-30.

14. 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 coverage manual and any riders or 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 Coverage Manual

We will interpret the provisions of this coverage manual 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 coverage manual. If any benefit described in this coverage manual is subject to a determination of medical necessity, we will make that factual determination. Our interpretations and determinations are final and conclusive.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your coverage manual. You should become familiar with the entire document.

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this coverage manual at any time. Any amendment or

modification will be in writing and will be as binding as this coverage manual. If your contract is terminated, you may not receive benefits.

Authorized Group Health 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 coverage manual. This coverage manual 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 39.

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 www.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

You have agreed in your application (or in documents kept by us or your employer or group sponsor) 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 in your application, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application, 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.

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 www.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 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.

Health Insurance Portability and Accountability Act of 1996

Group Sponsor's Certification of Compliance

Your group health plan, any business associate servicing your group health plan, or Wellmark will not disclose protected health information to your group sponsor unless your group sponsor certifies that group health plan documents have been modified to incorporate this provision and agrees to abide by this provision. Your receipt of this coverage manual means that your group sponsor has modified your group health plan documents to incorporate this provision, and has provided certification of compliance to Wellmark.

Purpose of Disclosure to Group Sponsor

Your group health plan, any business associate servicing your group health plan, or Wellmark will disclose protected health information to your group sponsor only to permit the group sponsor to perform plan administration of the group health plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts

160-64). Any disclosure to and use by your group sponsor of protected health information will be subject to and consistent with the provisions identified under *Restrictions on Group Sponsor's Use and Disclosure of Protected Health Information and Adequate Separation Between the Group Sponsor and the Group Health Plan*, later in this section.

Neither your group health plan, nor Wellmark, or any business associate servicing your group health plan will disclose protected health information to your group sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan members.

Neither your group health plan, nor Wellmark, or any business associate servicing your group health plan will disclose protected health information to your group sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the group sponsor.

Restrictions on Group Sponsor's Use and Disclosure of Protected Health Information

Your group sponsor will not use or further disclose protected health information, except as permitted or required by this provision, or as required by law.

Your group sponsor will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the restrictions and conditions of this provision with respect to protected health information and electronic protected health information.

Your group sponsor will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the group sponsor.

Your group sponsor will report to the group health plan, any use or disclosure of protected health information that is inconsistent with the uses and disclosures

stated in this provision promptly upon learning of such inconsistent use or disclosure.

Your group sponsor will make protected health information available to plan members in accordance with 45 Code of Federal Regulations § 164.524.

Your group sponsor will make protected health information available, and will on notice amend protected health information, in accordance with 45 Code of Federal Regulations § 164.526.

Your group sponsor will track disclosures it may make of protected health information so that it can provide the information required by your group health plan to account for disclosures in accordance with 45 Code of Federal Regulations § 164.528.

Your group sponsor will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your group health plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your group sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the group health plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, your group sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Your group sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality,

integrity, and availability of electronic protected health information.

Your group sponsor will promptly report to the group health plan any of the following incidents of which the group sponsor becomes aware:

- unauthorized access, use, disclosure, modification, or destruction of the group health plan's electronic protected health information, or
- unauthorized interference with system operations in group sponsor's information systems that contain or provide access to group health plan's electronic protected health information.

Adequate Separation Between the Group Sponsor and the Group Health Plan

Certain individuals under the control of your group sponsor may be given access to protected health information received from the group health plan, a business associate servicing the group health plan, or Wellmark. This class of employees will be identified by the group sponsor to the group health plan and Wellmark from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the group health plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the group sponsor provides for the group health plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the group sponsor, for any use or disclosure of protected health information in violation of or noncompliance with this provision. The group sponsor will promptly report such violation or noncompliance to the group

health plan, and will cooperate with the group health plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

Your group sponsor will ensure that these provisions for adequate separation between the group sponsor and the group health plan are supported by reasonable and appropriate security measures.

Nonassignment

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. You are prohibited from assigning any claim or cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan or rights to payment will be void.

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. Any action brought because of a claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.

Legal Action

You shall not start any legal action against us unless you have exhausted the applicable appeal process described in the *Appeals* section.

You shall not bring any legal or equitable action against us because of a claim under this group health plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in

which the services or supplies were provided.

Medicaid Enrollment

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.

Subrogation

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 are injured as a result of the act of a third party 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 injury from money received from the third party or its insurer, 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 of the following:

- The responsible person or that person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage, including but not limited to homeowner's, motor vehicle, or medical payments insurance.

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 non-medical 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 were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such 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 injury, 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
636 Grand Avenue, Station 151
Des Moines, IA 50309-2565

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.
- 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 benefits 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 of benefits paid under this 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, 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.

Notice

If a specific address has not been provided elsewhere in this coverage manual, you may send any notice to Wellmark's home office:

Wellmark Blue Cross and Blue Shield of
Iowa
636 Grand Avenue
Des Moines, IA 50309-2565

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.

Glossary

The definitions in this section are terms that are used in various sections of this coverage manual. 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, whether or not it is covered under this group health plan.

Benefit Year. A calendar year, starting over each January 1. A benefit year continues even if you change coverage under group health plans sponsored by your employer or group sponsor and administered by Wellmark.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

BlueCard Program. The Blue Cross and Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of PPO Network providers throughout the United States.

Creditable Coverage. Any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

- 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.

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.

Medically Urgent Situation. A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits 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 Provider. A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan.

Outpatient. Services received, or a person receiving services, in a practitioner's office, the home, the outpatient department of a hospital, or an ambulatory surgery center.

Participating Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield Plan but not with a preferred provider program.

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.

PPO Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield preferred provider program.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this coverage manual, that may be used to diagnose or treat a medical condition.

Spouse. A husband or wife as the result of a marriage that is legally recognized in Iowa, including common law.

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.

Index

A

abortion	13
accidental injury.....	12
acupressure	11
acupuncture	7, 11
acute rehabilitation facilities	29
addiction	7, 11
admissions	29, 31
adoption	37, 39
advanced registered nurse practitioners	8, 18
allergy services	7, 11
ambulance services	7, 11
ambulatory facility	15
ambulatory facility services	12
amount charged	35
anesthesia.....	7, 11, 12
annulment.....	39
appeals	29, 47
assignment of benefits	57
athletic trainers	18
audiologist.....	13, 18
authority to terminate or amend	53
authorized representative	53

B

benefit coordination.....	43
benefit year.....	33
benefit year deductible.....	3
benefits maximum	5
bereavement counseling	12
biological products.....	19
blood.....	7, 11
BlueCard program	28, 33
bone marrow transplants.....	21
braces	14, 16, 20
brain injuries.....	32
breast reconstruction	20

C

care coordination	29
case management.....	31
changes of coverage	39

chemical dependency	7, 11
chemical dependency treatment facility	15
chemotherapy	7, 11
child support order	37
children	37, 39, 44
chiropractic office visit copayment	3, 4
chiropractic services	8, 17, 18
chiropractors.....	8, 18
claim filing	41, 43
claim forms	41
claim payment	42
COBRA coverage.....	39, 40
coinsurance.....	3, 4, 33
communication disorders.....	17
community mental health center	15
complications.....	25
concealment of material fact	40
conditions of coverage.....	23
continued stay review	31
contraceptives.....	19
contract	53
contract amendment	53
contract interpretation	53, 57
convenience items	25
coordination of benefits.....	43
coordination of care.....	29
copayment.....	4
cosmetic services	7, 11
cosmetic surgery	9, 20
counseling	7, 12
coverage changes	39, 53
coverage continuation	40
coverage effective date.....	37
coverage eligibility	37, 39
coverage termination.....	39, 40
creditable coverage	39, 40
custodial care	14
cystic fibrosis	32

D

death	39
deductible	3

deductible amounts 3
 degenerative muscle disorders 32
 dental services 7, 12
 dependents 37, 39, 44
 diabetes 8, 12
 diabetic education 8, 12
 dialysis 7, 12
 dietary products 17
 disabled dependents 37
 divorce 39
 doctors 8, 18
 doctors of osteopathy 8, 18
 drug abuse 7, 11
 drugs 9, 19

E

effective date 37
 eligibility for coverage 37, 39
 emergency services 8, 12
 emergency services copayment 3, 4
 employment physicals 19
 EOB (explanation of health care benefits) 42
 ERISA 49
 exclusions 23, 24
 experimental services 24
 explanation of health care benefits (EOB) 42
 eye services 9, 21
 eyeglasses 21

F

facilities 8, 15
 family counseling 12
 family deductible 3
 family member as provider 25
 fertility services 8, 13
 filing claims 41, 43
 foot care (routine) 19
 foot doctors 9, 18
 foreign countries 28
 foster children 37, 39
 fraud 40

G

genetic testing 8, 13, 30
 glucose strips 19
 government programs 25, 43

gynecological examinations 19

H

hair pieces 9, 21
 hearing services 8, 13
 hemophilia 32
 high risk pregnancy 32
 home health services 8, 13, 29, 31, 32
 home infusion therapy 19, 29, 31
 home office (Wellmark) 60
 home skilled nursing 14
 home/durable medical equipment 8, 14, 30
 hospice respite care 15
 hospice services 8, 15, 29, 31
 hospital services 12, 40
 hospitals 8, 15

I

ID card 27, 28
 illness 8, 15
 immunizations 9, 19
 impacted teeth 12
 infertility treatment 8, 13
 information disclosure 54
 inhalation therapy 8, 14, 16
 injury 8, 15
 inpatient facility admission 29, 31
 inpatient services 33, 40
 insulin supplies 16
 investigational services 24

K

kidney dialysis 12

L

L.P.N. 14
 laboratory services 9, 21
 legal action 57
 licensed independent social workers 8, 18
 licensed practical nurses 14
 lifetime benefits maximum 3, 5, 25, 39
 limitations of coverage 5, 7, 23, 25
 lodging 9, 21

M

mammograms 19
 marriage 39

marriage counseling..... 12
 massage therapy..... 18
 mastectomy20
 maternity services 8, 16
 maximum allowable fee 35
 medicaid enrollment..... 57
 medical doctors 8, 18
 medical equipment 8, 14
 medical supplies..... 8, 16
 medical support order 37
 medically necessary 23
 Medicare.....39, 43
 medicines 9, 19
 mental health services 8, 16
 mental health treatment facility 15
 mental illness 8, 16
 military service..... 25
 misrepresentation.....40
 morbid obesity treatment 8, 17
 motor vehicles 8, 17
 muscle disorders 32
 musculoskeletal treatment 8, 17
N
 network savings 35
 newborn care..... 19
 newborn children39
 nicotine dependence 17, 19
 nonassignment of benefits..... 57
 nonmedical services..... 8, 18, 25
 nonparticipating providers34
 notice.....60
 notification of change 39
 notification requirements 29
 nursing facilities..... 15, 29, 40
 nutritional products.....17
O
 obesity surgery30
 obesity treatment 8, 17
 occupational therapists..... 9, 18
 occupational therapy8, 14, 18
 office visit copayment 3, 4
 optometrists 9, 18
 oral contraceptives..... 19

oral surgeons9, 18
 organ transplants.....9, 21
 orthotics 8, 18
 osteopathic doctors..... 8, 18
 other insurance..... 25, 43
 out of state facilities..... 29
 out-of-area coverage 28, 33
 out-of-pocket maximum..... 3, 4
 oxygen 14, 16

P

pap smears19
 participating providers 27
 payment arrangements..... 35
 payment in error 60
 payment obligations 3, 5, 23, 26, 30, 33
 personal items 25
 physical examinations19
 physical therapists9, 18
 physical therapy.....8, 14, 18
 physician assistants9, 18
 physicians 8, 18
 plastic surgery..... 7, 11
 podiatrists9, 18
 PPO providers..... 27, 34
 practitioners..... 8, 18
 precertification 15, 25, 29
 preferred provider organization (PPO)..... 27
 pregnancy 15, 16
 pregnancy (high risk) 32
 prenatal services16
 prescription drugs9, 19
 preventive care.....9, 19
 prior approval 30
 privacy..... 54
 prosthetic appliances..... 9, 14, 20
 psychiatric services16
 psychologists.....9, 18

Q

qualified medical child support order 37

R

R.N. 8, 14, 16, 18
 radiation therapy 7, 11
 reconstructive surgery9, 20, 30

registered nurses..... 8, 14, 16, 18
 reimbursement of benefits..... 57, 60
 release of information..... 54
 removal from coverage 39
 residential treatment 11, 17
 residential treatment facility 15
 respiratory therapy 8, 14, 16
 rights of action 57
 rights of appeal..... 47
 routine services 9, 19

S

self-help..... 9, 20
 service area..... 28
 service maximums 7
 sexual identification disorders 17
 skilled nursing services..... 14
 sleep apnea..... 9, 20, 30
 social workers..... 8, 18
 speech pathologists 9, 18
 speech therapy 9, 20, 30
 spinal cord injuries 32
 sports physicals 19
 spouses 37, 39
 stepchildren 37
 sterilization 13
 students..... 37, 39
 subrogation 57
 surgery..... 9, 21

surgical facility..... 15
 surgical facility services 12
 surgical supplies 8, 16

T

temporomandibular joint disorder 9, 21
 termination of coverage..... 39, 40
 third party liability..... 25
 TMD (temporomandibular joint disorder) ... 9, 21
 tooth removal..... 12
 transplants 9, 21, 30, 32
 travel 9, 21
 travel physicals 19
 tubal ligation..... 13

V

vaccines..... 19
 vasectomy 13
 vehicles..... 8, 17
 vision services 9, 21

W

weight reduction 8, 17, 30
 well-child care..... 9, 19
 wigs 9, 21
 workers' compensation..... 25, 59

X

x-rays 9, 21

