Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund

Summary Plan Description ("SPD")

Effective January 1, 2017

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

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Your Plan Identification at a Glance

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

Your Plan Identification at a Glance

Agent for Service of Legal Process	The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the following address: Board of Trustees of the Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund c/o Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401 Service of legal process may also be made upon any Trustee.
Claims Administrator for Medical Benefits	Wellmark Blue Cross and Blue Shield of Iowa 1331 Grand Avenue Des Moines, IA 50309-2901
Prescription Benefit Manager	Express Scripts One Express Way St. Louis, MO 63121
Claims Administrator for HRA and Short Term Disability Benefits	Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401
Claims Administrator for Dental Benefits	Delta Dental of Iowa P.O. Box 9000 Johnston, IA 50131-9000
Claims Administrator for Vision Benefits	FAA/EyeMed Vision Care Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
Provider of Employee Assistance Benefits	Mercy Medical Center 701 10th Street SE Cedar Rapids, IA 52403
COBRA Administrator	Auxiant 424 1st Avenue NE, Suite 200 Cedar Rapids, IA 52401
Insurer of Life and Accidental Death & Dismemberment ("AD&D")	EMC National Life Company P.O. Box 9202 Des Moines, IA 50306-9202

Your Plan Identification at a Glance

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

About This Summary Plan Description

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

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

Interpreting this Summary Plan Description and the Master Plan Document
Only the full Board of Trustees is authorized to interpret the terms of the Plan described in this SPD and will determine the answer to all questions that arise under it. The Trustees have the sole discretion to determine whether you meet the Plan's written eligibility requirements, or to interpret any other term in this SPD. Such interpretations and determinations will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan.

Authority to Terminate, Amend, or Modify the Plan
Only the Board of Trustees has the right, power and authority to terminate, amend, or modify the coverage described in this SPD at any time as may, in their discretion, be proper or necessary for the sound and efficient administration of the Plan, at any time, provided that such changes are not inconsistent with law. The Trustees intend that the terms of the Plan, including those relating to coverage and benefits, are legally enforceable while they are in effect. The right to change or eliminate any and all aspects of benefits provided to Participants and their dependents is a right specifically reserved to the Trustees. Notices of any amendment to or modification of this SPD will be in writing and will be provided to each Participant within the time required by applicable regulations; such written notice shall be as binding as this SPD. Please note that some changes may take effect before you are notified of such changes. This document does not describe changes to the Plan that occur after this SPD is printed.

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

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

Non-Assignment
Except for the assignment of the payment of benefits (*See Other Payment Provisions*) or as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge, or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge, or otherwise encumber any such amount, whether presently or hereafter payable, shall be void and will not be recognized by the Plan as an assignment. The Plan shall not be liable for or subject to the debts and/or liabilities of any person entitled to any amount payable under the Plan or any part thereof.

About This Summary Plan Description

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

Legal Action
You shall not start any legal action against the Plan or the Trustees unless you have exhausted the applicable appeal process and the external review process completely, as described in the *Claims and Appeals Procedures* section of this SPD.

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

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

Miscellaneous
Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan. Pronouns used in this SPD shall include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural or singular number, according to the context.

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

Your Rights Under ERISA

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

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

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

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

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

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

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

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

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

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

Eligibility and Participation

Eligibility - Bargaining Unit Employees
Eligibility - Non-Bargaining Unit Employees
Eligibility - Dependents
Coverage Change Events
Coverage Continuation

Eligibility - Bargaining Unit Employees

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

Contributions and Your Health Reimbursement Account ("HRA") / Dollar Bank

Effective January 1, 2008, the contributions made by a Contributing Employer on your behalf, pursuant to a collective bargaining agreement, will be credited to your HRA. The balance of your HRA will be reduced by the monthly benefit plan premium charge, as determined by the Trustees, due for your benefits under the Plan. Any contribution amounts remaining after your monthly benefit plan premium charge is paid will remain in your HRA and will accumulate for future use, as allowed by the Plan. HRA funds are also available to reimburse medical, dental and vision expenses that are not reimbursable from other sources. See *HRA Benefits* section of this SPD.

Statements including the HRA balance will be sent to Participants monthly. Reimbursement requests will be processed around the 10th of the month, and requests for reimbursement must be received no later than the 1st of the month, or the request will carry forward to the next month. For example, requests must be received by May 1st to be processed around May 10th, and the check will be sent out around the 15th along with the monthly statement. The Claims Administrator will process reimbursements only once per month and the HRA must have at least $100 in reimbursement requests before the Claims Administrator issues a check. Reimbursement checks will be mailed along with the monthly statement.

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

Initial Eligibility

Once a bargaining unit Employee meets the service requirement, the bargaining unit Employee will gain initial eligibility to participate in the Plan. Prior to June 1, 2015, the service requirement was satisfied upon the Employee's completion of 500 hours of work in covered employment within a 12-month period; the 500 hours of work service requirement was reduced to 304 hours of work, effective June 1, 2015. The Employee's coverage under the Plan will begin on the first day of the third month after satisfying the service requirement. The following is an example:

Eligibility - Bargaining Unit Employees

Month A	Month B	Month C	Month D
Employee meets the 304 hour service requirement	Contributing Employer reports Employee's hours worked for Month A to the Administrative Manager	Administrative Manager sends a monthly statement to the Employee reflecting contributions to the Plan for the hours worked by the Employee in Month A	The Employee's (now a Plan Participant) coverage under the Plan begins on the first day of this month
Example: If an Employee satisfied the service requirement in January, coverage under the Plan would begin April 1st.			

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

Continuation of Eligibility

Employer Contributions
Once you meet the initial eligibility requirements, set forth above, your eligibility to participate in the Plan will continue by deducting the monthly benefit plan premium charge, as determined by the Trustees, from your HRA, for as long as you remain actively at work, or available for work, at covered employment with a Contributing Employer that contributes to the Plan on your behalf.

Example: Eligibility for coverage under the Plan in the month of April will be determined based on contributions paid to the Plan for hours worked in January. Contributions for hours worked in January are required to be paid to the Plan by February 15th.

There are three Plan coverage options: Brown, Orange and Yellow. The default Plan option is the Orange Plan, in which you shall be enrolled for the remainder of the Plan Year in which you initially become eligible, unless you have filed an enrollment form requesting coverage in either the Brown or Yellow options in advance of becoming eligible. You may elect to change Plan options at the next annual enrollment period to begin as of the following Plan Year (January 1). If you do not elect to make a change during the annual enrollment period, you will stay in the Plan option in which you are currently enrolled.

Continuation of Eligibility without Employer Contributions
You may continue to be covered under the Plan so long as you have sufficient funds in your HRA (or Dollar Bank, if applicable) to cover your monthly benefit plan premium charge. Coverage under the Plan shall be terminated at the end of the coverage month in which your HRA balance (and Dollar Bank balance, if applicable) is reduced to zero. For example, because eligibility for coverage under the Plan in the month of April is determined based on contributions paid to the Plan in the month of February, if your HRA balance (and Dollar Bank balance, if applicable) is reduced to zero in March, your coverage under the Plan will terminate at the end of February.

Eligibility - Bargaining Unit Employees

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

- A Participant stops working for a Contributing Employer when such work is otherwise available; or
- A Participant goes to work for an employer in the electrical industry that is not signatory to a collective bargaining agreement with an I.B.E.W. local union.

A Participant's Dollar Bank (but not HRA) will be reduced to a zero balance when a Participant changes job classifications and falls into an employment category not covered by the collective bargaining agreement in effect between the Contributing Employer and I.B.E.W. Local 405 at the time of such change of employment. If such Participant returns to covered employment within 12 months of his or her Dollar Bank balance being reduced to zero because he or she was appointed to an employment category described in the collective bargaining agreement, the Participant's Dollar Bank balance will be restored to such Participant upon application and approval by the Trustees.

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

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

Once the Participant reaches the maximum number of self-payment contributions, COBRA continuation coverage may apply.

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

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

- The date the Participant is no longer totally disabled; or
- The date the Participant becomes eligible for Medicare or a state sponsored Medicaid program.

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

- The date the Participant's dependent child(ren) no longer meet the definition of eligible dependent; or
- The date the Participant's Spouse or dependent child(ren) become eligible for Medicare or Medicaid, even though the Participant's Spouse or dependent child(ren) may not, in fact, be receiving Medicare or Medicaid.

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

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

- The first day of the month in which the Participant does not meet the Plan's "Continuation of Eligibility" requirements; or
- The date in which the Participant becomes eligible for benefits under any other group health plan; or
- The last day of the month in which the Participant ceases working at covered employment in the I.B.E.W. Local 405 jurisdiction.

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

- The Participant filed a written notification of leave with the Administrative Manager and terminated his or her past eligibility prior to the date he or she left the I.B.E.W. Local 405 jurisdiction;
- The Participant returns to covered employment in the I.B.E.W. Local 405 jurisdiction within 12 calendar months of his or her termination of past eligibility; and
- The Participant performed at least 500 hours (reduced to 304 hours, effective June 1, 2015) of covered employment for which a Contributing Employer made contributions on his or her behalf during the three calendar months immediately prior to the month in which he or she left the I.B.E.W. Local 405 jurisdiction and his or her termination of eligibility occurred.

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

Eligibility - Bargaining Unit Employees

Eligibility for Participants Working in the Electrical Industry, Outside the I.B.E.W. Local 405 Jurisdiction, with Reciprocity

The Trustees have entered into reciprocity agreements with the trustees of similar I.B.E.W. health and welfare funds operating in jurisdictions of other I.B.E.W. local unions. Under these agreements, contributions for hours worked at covered employment in the jurisdiction of another I.B.E.W. local union may be transferred to the Plan for use in continuing a Participant's eligibility.

The amount of contributions that may be transferred and the way such transfers are credited to Participant records are governed by the reciprocity agreements and by the administrative procedures adopted by the Trustees. A Participant should inquire about the availability of reciprocal transfers with the Administrative Manager BEFORE he or she leaves the I.B.E.W. Local 405 jurisdiction.

Continuation of Eligibility for Dependents in the Event of a Participant's Death

If a Participant dies, eligibility for such Participant's surviving dependents will continue automatically, without self-payment contributions, so long as the surviving dependents continue to meet the definition of dependent, until the later of:

- The eligibility termination date based on when the deceased Participant's HRA (and Dollar Bank, if applicable) equals zero; or
- The last day of the sixth calendar month following the month in which the Participant died.

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

Continuation of Eligibility When Entering Qualified Military Service

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

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

Eligibility - Bargaining Unit Employees

Reinstatement of Eligibility

Participants
Unless stated otherwise in this SPD, the requirements for reinstatement of eligibility for coverage under the Plan are the same as the requirements for obtaining initial eligibility. Upon reinstatement of eligibility, the Participant and his or her eligible dependents, if any, become eligible for all benefits provided under the Plan.

Retiree Program
Bargaining unit Participants who meet the General Eligibility Requirements below may continue coverage under the Plan as described below. Retiree coverage does not include Short Term Disability Benefits, Life Insurance or Accidental Death & Dismemberment Insurance.

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

- The Participant is at least 62 years old;
- The Participant has been eligible to participate in the Plan for at least nine consecutive months during each of the five calendar years immediately prior to his or her request for coverage under this retiree program; and
- The Participant is receiving benefits from any retirement or deferred savings plan of any I.B.E.W. local union, or is receiving benefits from the International Brotherhood of Electrical Workers Pension Plan, the National Electrical Workers Benefit Fund, or from the Social Security Administration.

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

The self-payment contribution amounts required for eligibility in the Plan's retiree program are determined by the Trustees as needed. Self-payments must be received by the Administrative Manager by the 28th of the month before the coverage month for which payment is due. All notices are sent to the last known address on file at the Plan Office, so it is important that any address changes be reported to the Administrative Manager immediately.

Once a retired Participant reaches age 65 or is entitled to Medicare benefits, the coverage under the Plan will terminate regardless of the retiree's HRA balance (and Dollar Bank balance, if applicable), or whether or not the retiree chooses to purchase Medicare Part B coverage. Coverage will end as of the last day of the month preceding the month in which the Participant reaches age 65, or becomes entitled to Medicare benefits, whichever occurs earlier. If the retired Participant has no dependents, the retiree's Dollar Bank balance will be zeroed out at this point. The retiree may continue to receive medical reimbursements from his or her HRA.

The retiree's Spouse may continue coverage under the HRA (and Dollar Bank, if applicable), including self-paying under the retiree program, until the earliest of: (a) the last day of the month preceding the month in which the retiree's Spouse turns 65, (b) the last day of the month preceding the month in which the retiree's Spouse becomes entitled to Medicare benefits, or (c) the last day of the month in which the retiree's Spouse ceases to meet the Plan's definition of an eligible Spouse.

Any dependent children of the retiree may continue under the HRA (and Dollar Bank, if applicable), including self-paying under the retiree program, until the earliest of: (a) the last day of the month preceding the month in which the retiree's Spouse turns 65; or (b) the last day of the month preceding the month in which the retiree's Spouse becomes entitled to Medicare benefits; or (c) the last day of the month in which the child no longer meets the requirements to be considered an eligible dependent child of the retiree.

Employment Changes May Affect Eligibility

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

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

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

If a bargaining unit Employee changes job classifications from covered employment to non-covered employment, but remains covered by the Plan as a non-bargaining unit Employee, the Participant's HRA will remain available for payment of claims, but shall receive no further contributions, and his or her Dollar Bank will be zeroed out. If the Participant goes back to covered employment within twelve months from the beginning of the non-covered employment, the Participant may apply to the Trustees for reinstatement of his or her Dollar Bank.

Change of Requirements for Eligibility

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

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

Eligibility - Non-Bargaining Unit Employees

The Trustees have agreed to allow non-bargaining unit ("NBU") Employees of certain Contributing Employers and other Employers (e.g., I.B.E.W. Local 405 and the Cedar Rapids Electrical Apprenticeship Training and Educational Trust) to participate in the Plan. These Employers must agree to follow the terms of the Trust Agreement, agree to contribute to the Plan on behalf of such NBU Employees and must execute a separate written participation agreement, approved by the Trustees, in order for its NBU Employees to be eligible to participate in the Plan. Eligibility requirements, payroll deduction amounts and benefits received under the Plan are established by the Employer, approved by the Trustees, and set forth in a written participation agreement. Unless otherwise specified by the participation agreement, coverage for full-time NBU Employees becomes effective as of the first of the month following 30 days of full-time service. "Full-time" is defined by the Employer.

All NBU Employees are eligible for medical, prescription drug, dental, vision and life insurance benefits under the Plan. NBU Employees are not eligible for HRA benefits under the Plan. NBU Employees are eligible for short term disability ("STD") benefits only if the Employer has agreed to sponsor such benefits for NBU Employees under the participation agreement. Finally, NBU Employees are not eligible for retiree benefits.

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

Eligibility - Dependents

The following persons may be eligible for dependent coverage under the Plan for medical, prescription drug, dental and vision coverage:

Lawful Spouse – A Participant's lawful spouse, if not legally separated or divorced. The Administrative Manager may require documentation proving a legal marital relationship exists. Domestic partnerships are not considered eligible for spousal coverage. Benefits received by a Participant's Spouse are not tax deductible for the employer and such benefits are taxable to the Participant.

Effective June 26, 2015, a "lawful spouse" is a man or woman lawfully married to a covered Participant under any state law (or the law of any U.S. territory or possession or any foreign jurisdiction with legal authority to sanction marriages), including common law marriage, regardless of where the couple lives.

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

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

Children Entitled to Coverage
The term "child" or "children" as referenced in the preceding sections includes:

- A Participant's natural child;
- A Participant's adopted child (from the date of placement);
- A Participant's stepchild;
- A Participant's grandchild until the dependent grandchild's parent is age 19;
- Any other child for whom the Participant has legal guardianship or for a child for whom the Participant had noted legal guardianship on the child's 18th birthday (proof is required).

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

Eligibility - Dependents

Qualified Medical Child Support Orders (QMCSOs)
A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for an Employee's child that instructs the Plan to cover the child, the Administrative Manager will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, the child will be enrolled in the Plan as the Employee's dependent, and the Plan will be required to pay benefits as directed by the order.

Participants may obtain, without charge, a copy of the procedures governing QMCSOs from the Administrative Manager.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Dependent Effective Date
Dependent coverage is available only for medical, prescription drug, dental and vision benefits. Provided the Employee/Participant timely files an application for coverage in the format approved by the Trustees, coverage becomes effective as follows:

- If the Employee has eligible dependents at the time he or she initially enrolls in coverage, such dependents shall become covered on the same date as the Employee.

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

- If a dependent is acquired due to a court order of guardianship or marriage, the coverage will be effective as of the date of the court order or marriage, if coverage is requested and the dependent is enrolled within 31 days of the event. If enrollment is requested after the 31-day time period, then coverage is effective on the first day of the month after the completed enrollment form is received by the Administrative Manager.

- If a dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated due to loss of eligibility, coverage will be effective on the first day of the month after a completed enrollment form is received by the Administrative Manager, provided it is received within 60 days of the termination of the other coverage. If enrollment is requested after the 60-day time period, then coverage is effective on the first of the month after the completed enrollment form is received by the Administrative Manager.

- If a dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, coverage will be effective on the first day of the month after a completed enrollment form is received by the Administrative Manager, provided it is received within 60 days of the termination of the other coverage. If enrollment is requested after the 60-day time period, then coverage is effective on the first day of the month after the completed enrollment form is received by the Administrative Manager.

Eligibility - Dependents

- If a Participant is required to enroll a dependent child as a result of a Medical Child Support Order, the effective date of coverage shall be the first of the month following the date the order was received by the Administrative Manager, if it is approved as a QMCSO by the Administrative Manager.

Rules for Dual Eligibility

Employee/Spouse

Bargaining Unit Employee & Spouse.
If both spouses are eligible bargaining unit Employees, then both spouses must be enrolled as Participants. Each Participant can elect to enroll in any of the Plan options and enroll his/her Spouse and any eligible dependent children of the couple. The Plan will apply Coordination of Benefits rules, which may result in coverage of expenses up to 100% of the maximum allowable expense for services rendered.

Non-Bargaining Unit Employee & Spouse
With respect to medical, prescription drug, dental and vision coverage, if both spouses are eligible NBU Employees, then each spouse can enroll separately, but only one spouse can enroll eligible dependent children. Alternatively, one spouse (but not both) can enroll the entire family in one coverage unit. In the event one of the spouses loses eligibility, the remaining eligible spouse will have the opportunity to enroll him/herself and eligible dependents within 31 days of the event.

One Bargaining Unit Employee Spouse, one Non-Bargaining Unit Employee Spouse
A bargaining unit Employee must be enrolled as a Participant for Plan coverage. The bargaining unit Employee may enroll the NBU Spouse and any eligible dependent children as a family unit in any of the Plan options. Alternatively, each spouse may enroll separately as Participants, and one spouse (but not both) can elect to cover eligible dependent children. If one of the spouses loses eligibility as a Participant, the remaining spouse will have the opportunity enroll the entire family in regular family coverage within 31 days of the event, if appropriate.

Employee/Child

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

Non-Bargaining Unit Child.
If a Participant parent has an eligible dependent child who is also an eligible NBU Employee, the child may be enrolled as either a Participant or as a dependent of the parent, but not both.

Coverage Change and Termination Events

Enrollment Events
The following events may allow you as well as an affected Spouse or eligible child to enroll for coverage, and to move from one plan option to another:

- Birth, adoption, or placement for adoption by an approved agency.
- Marriage.
- Exhaustion of COBRA continuation coverage.
- You or your Spouse or dependent loses eligibility for creditable coverage or his or her employer or group sponsor ceases contribution to creditable coverage.
- Spouse or dependent child loses coverage through his or her employer.
- You lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) (the *hawk-i* plan in Iowa).
- You become eligible for premium assistance under Medicaid or CHIP.

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

- Addition of a natural child by court order.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

Disenrollment Events
The following events require you to notify the Administrative Manager to remove the affected family member from your coverage:

- Death.
- Divorce or annulment. Legal separation, also, may result in removal from coverage. If you become legally separated, notify the Administrative Manager.
- Medicare eligibility. If you become eligible for Medicare, you must notify the Administrative Manager immediately. If you are eligible for coverage under the Plan other than as a current Employee or a current Employee's Spouse, your Medicare eligibility may terminate this coverage.

In case of the following coverage removal events, the affected child's coverage may be continued until the end of the month on or after the date of the event:

- Child who is not developmentally disabled or physically handicapped reaches age 26.
- Marriage of a developmentally disabled or physically handicapped child age 26 or older.

Coverage Change and Termination Events

Requirement to Notify Administrative Manager
You must notify the Administrative Manager within 31 days of most events that change your coverage status, but within 60 days of events related to Medicaid or CHIP eligibility. If you enroll newly eligible dependents later than 31 or 60 day enrollment window following the event, you will not be allowed to change plan options at the same time, unless the later enrollment coincides with the annual enrollment season. If you do not provide timely notification of an event that terminates the eligibility of an affected family member, you and your Spouse may be held responsible for any benefits paid by the Plan after the family member lost eligibility for coverage, and your coverage may be terminated.

You must notify the Administrative Manager and enroll a newborn or newly adopted child within one year of the date of birth or placement for adoption in order for coverage to be retroactive to the date of birth or placement for adoption. If the child is enrolled later than one year from the date of birth or placement for adoption, coverage will be effective as of the first day of the month following the date of enrollment. If the child is enrolled later than 60 days following the birth or adoption, you will not be allowed to change plan options at the same time, unless the later enrollment coincides with the annual enrollment season.

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

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

- The end of the month in which you no longer meet the Plan's eligibility requirements;
- The date the Plan discovers you have perpetrated fraud or an intentional misrepresentation of material facts with respect to your application for coverage or benefits; or
- The Trustees discontinue or replace the Plan.

Continuation of Coverage Events

Certain laws require that coverage continue when it might otherwise end under the Plan. The following provisions outline those circumstances.

Family and Medical Leave ("FMLA")

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

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Plan will fully comply with USERRA. If any part of the Plan conflicts with USERRA, the conflicting provision will not apply. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with USERRA.

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

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

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

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

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

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

    - For a covered Employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered Employee to recover from the illness or injury. The period of recovery may not exceed two years.

    A covered Participant who elects to continue health plan coverage under the Plan during USERRA leave may be required to pay no more than 102% of the full premium under the Plan associated with the coverage for the Employer's other Employees. This is true except in the case of a covered Participant who is on USERRA leave for less than 31 days. When this is the case, the covered

Employee may not be required to pay more than the Employee's share, if any, for the coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the uniformed services and their family members are eligible to receive coverage under the TRICARE program (formerly CHAMPUS).

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

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

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

COBRA Continuation Coverage

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

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

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

Qualified Beneficiary Defined: In general, a Qualified Beneficiary can be:

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

- Any child who is born to or placed for adoption with a covered Participant during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a QMCSO. If, however, an individual is denied or not offered coverage under the

Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

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

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

- The death of a covered Participant.
- The termination (other than by reason of gross misconduct), or reduction of hours, of a covered Participant's eligibility.
- The divorce or legal separation of a covered Participant from the Participant's Spouse.
- A covered Participant's eligibility for enrollment in any part of the Medicare program.
- A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).

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

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if the Participant does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered Participant and eligible family members will be entitled to COBRA continuation coverage even if they failed to pay the individual premiums for coverage under the Plan during the FMLA leave.

Continuation of Coverage Events

rocedure for Obtaining COBRA Continuation Coverage: The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

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

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

Responsibility for Informing the COBRA Administrator of the Occurrence of a Qualifying Event: The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator has been timely notified that a Qualifying Event has occurred. The Contributing Employer will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- The end of employment or reduction of hours of employment,
- Death of the Participant,
- Commencement of a proceeding in bankruptcy with respect to the Contributing Employer, or
- Eligibility for enrollment of the Participant in any part of Medicare.

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

Continuation of Coverage Events

NOTICE PROCEDURES:

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

Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund
c/o Auxiant
424 1st Avenue, NE, Suite 200
Cedar Rapids, IA 52401
Fax: 319-866-9889
Email: cobra@auxiant.com

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

- the **name of the plan or plans** under which the individual lost or will be losing coverage;
- the **name and address of the Employee** covered under the plan;
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**; and
- the type of **Qualifying Event** and the **date** it occurred.

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

Be aware that there are other notice requirements in other contexts, such as in order to qualify for a disability extension.

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

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

Continuation of Coverage Events

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

1. The last day of the applicable maximum coverage period.

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

3. The date upon which the Trustees discontinue all coverage under the Plan.

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

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

6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    a. The earlier of:

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

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

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

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

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

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

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

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

    a. 36 months after the date the covered Participant becomes enrolled in the Medicare program; or
    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Participant's termination of employment or reduction of hours of employment.

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

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

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

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

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

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

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

Continuation of Coverage Events

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

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

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

Medical Benefits

Schedule of Medical Benefits
Medical Benefit Payment Structure
Medical Benefit Description - Covered and Not Covered
General Conditions of Medical Coverage,
Exclusions and Limitations
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Medical Benefit Definitions

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

AllianceSelect℠

Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund

Plans Brown, Orange, and Yellow

NOTICE

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

QUESTIONS

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

Schedule of Medical Benefits

This section is intended to provide you with an overview of your payment obligations under the 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 SPD, 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.

Brown Plan		
	PPO Providers	**Non-PPO Providers**
Deductibles and Out-of-Pocket Maximums		
Deductible - you pay: **Per person** **Per family**	 $250 per Plan Year $500 per Plan Year	 $500 per Plan Year $1,000 per Plan Year
Out of Pocket Maximum - you pay: **Per person** **Per family**	$750 per Plan Year $1,500 per Plan Year	$1,500 per Plan Year $3,000 per Plan Year
Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. Deductibles, benefit maximums and out-of-pocket maximums that are identified as "PPO" or "Non-PPO" cross accumulate, which means that amounts paid for "PPO" services will be applied toward the deductibles and maximums in the "Non-PPO" category, and vice versa. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered charges for the remainder of the Plan Year, except for the following charges, which do not count towards the Out-of-Pocket Maximums: ineligible charges, amounts that exceed the Maximum Allowable Fee and hearing aids.		
Copayments		
Emergency Room - you pay:	$50 per date of visit	$50 per date of visit
Office Visit - you pay:	$15 per visit	None
Urgent Care - you pay:	$15 per visit	None

Schedule of Medical Benefits

Brown Plan		
	PPO Providers	**Non-PPO Providers**
Coinsurance		
Preventive Care - you pay:	0% (deductible waived)	0% (deductible waived)
Voluntary Sterilization - you pay:	0% (deductible waived)	0% (deductible waived)
Emergency Room - you pay:	10% after deductible	10% after deductible
Office Visits - you pay:	0% (deductible waived)	30% after deductible
Urgent Care - you pay:	0% (deductible waived)	30% after deductible
Chiropractic Services- you pay:	20% after deductible	40% after deductible
Hearing Aids - you pay:	50% (deductible waived)	50% (deductible waived)
Self-administered Injectable Drugs - you pay:	10% after deductible	10% after deductible
Prescription Drugs Purchased through the Veteran's Hospital - you pay:	10% (deductible waived)	10% (deductible waived)
All other prescription drugs are subject to the *Prescription Drug Program*, set forth in a separate section of this SPD.		
All other covered services - you pay:	10% after deductible	30% after deductible

Schedule of Medical Benefits

Orange Plan (Default Plan)		
	PPO Providers	**Non-PPO Providers**
Deductibles and Out-of-Pocket Maximums		
Deductible - you pay: **Per person** **Per family**	 $500 per Plan Year $1,000 per Plan Year	 $1,000 per Plan Year $2,000 per Plan Year
Out of Pocket Maximum - you pay: **Per person** **Per family**	 $1,000 per Plan Year $2,000 per Plan Year	 $2,000 per Plan Year $4,000 per Plan Year
Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. Deductibles, benefit maximums and out-of-pocket maximums that are identified as "PPO" or "Non-PPO" cross accumulate, which means that amounts paid for "PPO" services will be applied toward the deductibles and maximums in the "Non-PPO" category, and vice versa. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered charges for the remainder of the Plan Year, except for the following charges, which do not count towards the Out-of-Pocket Maximums: ineligible charges, amounts that exceed the Maximum Allowable Fee and hearing aids.		
Copayments		
Emergency Room - you pay:	$50 per date of visit	$50 per date of visit
Office Visit - you pay:	$20 per visit	None
Urgent Care - you pay:	$20 per visit	None
Coinsurance		
Preventive Care - you pay:	0% (deductible waived)	0% (deductible waived)
Voluntary Sterilization - you pay:	0% (deductible waived)	0% (deductible waived)

Schedule of Medical Benefits

Orange Plan (Default Plan)		
	PPO Providers	**Non-PPO Providers**
Emergency Room - you pay:	20% after deductible	20% after deductible
Office Visits - you pay:	0% (deductible waived)	30% after deductible
Urgent Care - you pay:	0% (deductible waived)	30% after deductible
Chiropractic Services - you pay:	30% after deductible	40% after deductible
Hearing Aids - you pay:	50% (deductible waived)	50% (deductible waived)
Self-administered Injectable Drugs - you pay:	20% after deductible	20% after deductible
Prescription Drugs Purchased through the Veteran's Hospital - you pay:	10% (deductible waived)	10% (deductible waived)
All other prescription drugs are subject to the *Prescription Drug Program*, set forth in a separate section of this SPD.		
All other covered services - you pay:	20% after deductible	30% after deductible

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
Deductibles and Out-of-Pocket Maximums		
Deductible - you pay: **Per person** **Per family**	 $1,500 per Plan Year $3,000 per Plan Year	 $3,000 per Plan Year $6,000 per Plan Year

Schedule of Medical Benefits

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
Out of Pocket Maximum - you pay: **Per person** **Per family**	 $3,000 per Plan Year $6,000 per Plan Year	 $6,000 per Plan Year $12,000 per Plan Year
Family amounts are reached from amounts accumulated on behalf of any combination of covered family members. Deductibles, benefit maximums and out-of-pocket maximums that are identified as "PPO" or "Non-PPO" cross accumulate, which means that amounts paid for "PPO" services will be applied toward the deductibles and maximums in the "Non-PPO" category, and vice versa. Once the Out-of-Pocket Maximum is reached, the Plan will pay 100% of covered charges for the remainder of the Plan Year, except for the following charges, which do not count towards the Out-of-Pocket Maximums: ineligible charges, amounts that exceed the Maximum Allowable Fee and hearing aids.		
Copayments		
Emergency Room - you pay:	$50 per date of visit	$50 per date of visit
Office Visit - you pay:	$30 per visit	None
Urgent Care - you pay:	$30 per visit	None
Coinsurance		
Preventive Care - you pay:	0% (deductible waived)	0% (deductible waived)
Voluntary Sterilization - you pay:	0% (deductible waived)	0% (deductible waived)
Emergency Room - you pay:	20% after deductible	20% after deductible
Office Visits - you pay:	0% (deductible waived)	40% after deductible
Urgent Care - you pay:	0% (deductible waived)	40% after deductible

Schedule of Medical Benefits

Yellow Plan		
	PPO Providers	**Non-PPO Providers**
Chiropractic Services - you pay:	30% after deductible	50% after deductible
Hearing Aids - you pay:	50% (deductible waived)	50% (deductible waived)
Self-administered Injectable Drugs - you pay:	20% after deductible	20% after deductible
Prescription Drugs Purchased through the Veteran's Hospital - you pay:	10% (deductible waived)	10% (deductible waived)
All other prescription drugs are subject to the *Prescription Drug Program*, set forth in a separate section of this SPD.		
All other covered services - you pay:	30% after deductible	40% after deductible

Medical Benefit Payment Structure

Deductible
This is a fixed dollar amount you pay for covered services in a Plan Year before medical benefits become available.

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

Deductible amounts you pay for PPO or participating and nonparticipating provider services apply toward meeting both the PPO and the participating/nonparticipating deductibles. The maximum deductible amount you pay is the participating/nonparticipating deductible.

Once you meet the deductible, then coinsurance applies.

Common Accident Deductible: When two or more covered family members are involved in the same accident and they receive covered services for injuries related to the accident, only one deductible amount will be applied to the accident-related services for all family members involved. However, you still need to satisfy the family (not the per person) out-of-pocket maximum.

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

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

Emergency Room Copayment

The emergency room copayment:

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

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

Office Visit Copayment

The office visit copayment:

- Applies to the office exam only received from PPO providers.
- Is taken once per date of service.

The office visit copayment does not apply to:

- Chiropractic services.

- Cochlear devices and related services.

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

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

Urgent Care Copayment

The urgent care copayment:

- Applies to urgent care facility services received from PPO providers.
- Is taken once per date of service.

Related practitioner services in an urgent care setting 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*. 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 Plan Year. Many amounts you pay for covered services during a Plan Year accumulate toward the out-of-pocket maximum. These amounts include:

- Deductible
- Coinsurance
- Copayments (emergency room, office visit and urgent care center)

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

There is an out-of-pocket maximum for services you receive from PPO providers, participating providers, and BlueCard providers. There is also an out-of-pocket maximum for services you receive from nonparticipating providers. These out-of- pocket maximums accumulate to one another.

However, amounts as shown in the Medical Schedule of Benefits do not apply to your out-of-pocket maximum. These amounts continue even after you have met your out-of-pocket maximum.

Benefits Maximums

Benefits maximums are the maximum benefit amounts that each Covered Person is eligible to receive. Benefits maximums are accumulated from benefits under this medical benefits plan and prior medical benefits plans sponsored by the Plan and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Medical Benefit Description - Covered and Not Covered

All covered services or supplies listed in this section are subject to the *Schedule of Medical Benefits* and the *Medical Benefit Payment Structure* described above, as well as all other general contract provisions and limitations described in this SPD. Also see the next section of this *Medical Benefit Description*, entitled *General Conditions of Coverage, Exclusions, and Limitations*. 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: Allergy testing, treatment and injections.
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:
• 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.
• During transportation, your medical condition requires the services that are provided only by an ambulance that is professionally staffed and specially equipped for taking sick or injured people to or from a health care facility in an emergency.
• In addition to the preceding requirements, for air ambulance services to be covered, all of the following conditions must be met:
  • The air ambulance has the necessary patient care equipment and supplies to meet your needs.
  • Your medical condition requires immediate and rapid ambulance transport that cannot be provided by a ground ambulance, or the point of pick up is inaccessible by a land vehicle.
  • Great distances, limited time frames, or other obstacles are involved in getting you to the nearest hospital with appropriate facilities for treatment.
  • Your condition is such that the time needed to transport you by land poses a threat to your health.

Not Covered: Professional air ambulance transport from a facility capable of treating your condition when performed primarily for your convenience or the convenience of your family, physician, or other health care provider.
Anesthesia
Covered: Anesthesia and the administration of anesthesia.
Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.
Blood and Blood Administration
Covered: Blood and blood administration.

Medical Benefit Description - Covered and Not Covered

Chemical Dependency Treatment
Covered: Treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs or alcohol as described in the most current Diagnostic and Statistical Manual of Mental Disorders.
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.
Clinical Trials
Covered: Medically necessary routine patient costs for items and services otherwise covered under the Plan furnished in connection with participation in an approved clinical trial related to the treatment of cancer or other life-threatening diseases or conditions, when a Covered Person is referred by a PPO or participating provider based on the conclusion that the Covered Person is eligible to participate in an approved clinical trial according to the trial protocol or the Covered Person provides medical and scientific information establishing that the Covered Person's participation in the clinical trial would be appropriate according to the trial protocol.
Not Covered: • Investigational or experimental items, devices, or services which are themselves the subject of the clinical trial. • Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient. • Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
Contraceptives
Covered: The following conception prevention, as approved by the U.S. Food and Drug Administration: • Contraceptive medical devices, such as intrauterine devices and diaphragms. • Implanted contraceptives. • Injected contraceptives.
Not Covered: Contraceptive drugs and contraceptive drug delivery devices, such as insertable rings and patches.
See Also: Separate *Prescription Drug Program* section of this SPD.
Cosmetic Services
Not Covered: Cosmetic services, supplies, or drugs if provided primarily to improve physical appearance. A service, supply or drug that results in an incidental improvement in appearance may be covered if it is provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect. You are also not covered for treatment for any complications resulting from a non-covered cosmetic procedure.
See Also: *Reconstructive Surgery* later in this section.

Medical Benefit Description - Covered and Not Covered

Counseling and Education Services

Covered: Bereavement counseling or services.

Not Covered:

- Family counseling or training services, and marriage counseling or training services. This includes services of volunteers or clergy.
- Education or educational therapy other than covered education for self-management of diabetes.

See Also:

- *Genetic Testing* later in this section.
- *Education Services for Diabetes* later in this section.
- *Mental Health Services* later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an outpatient. Inpatient removal is covered only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Orthodontic services required for surgical management of cleft palate.
- 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, indirect fabrications, dentures and bridges, and orthodontic services unrelated to accidental injuries or surgical management of cleft palate.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration) unrelated to accidental injuries or abnormal changes in the mouth due to injury or disease.

See Also:

- *Preventive Care* later in this section.
- Separate *Dental Benefits* section of this SPD.

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 when received from a PPO provider.
- All covered training or education must be prescribed by a licensed physician. Outpatient training or education must be provided by a state-certified program.
- The state-certified diabetic education program helps any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes.
- Benefit Maximums: 10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to two hours annually.

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

Emergency Services

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

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- 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 the Plan does not have contracts with nonparticipating providers and they may not accept Wellmark's payment arrangements for the Plan, you are responsible for any difference between the amount charged and the Plan's payment for a covered service.

See Also: *Choosing a Provider* section later in this *Medical Benefit Description*.

Fertility and Infertility Services

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

Not Covered:

- Abortion that is elective (except abortions performed when the life of the mother is at risk if the pregnancy goes to full term and complications resulting from a non-covered abortion).
- Infertility diagnosis and treatment.
- Infertility treatment if the infertility is the result of voluntary sterilization.
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent services.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

Medical Benefit Description - Covered and Not Covered

Genetic Testing

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

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

Hearing Services

Covered:

- Hearing examinations (covered at Office Visit level)
- Cochlear implants
- Hearing aids

Note: Discounts on hearing exams and hearing aids are available through EyeMed. Please see the Vision Care Benefits section of this SPD for more information.

Benefit Maximums:

- One routine hearing examination covered per Plan Year
- One pair of hearing aids covered up to a maximum benefit of $2,500 every 36 months

Home Health Services

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

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by Wellmark's 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.

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. The daily benefit for home skilled nursing services will not exceed Wellmark's daily maximum allowable fee for care in a skilled nursing facility. Home skilled nursing will be coordinated by a case manager. Custodial care is not included in this benefit.
- Inhalation Therapy.

- Medical Equipment.
- Medical Social Services.
- Medical Supplies.
- Occupational Therapy. Only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.
- Oxygen and Equipment for its administration.
- Parenteral and Enteral Nutrition, except enteral formula administered orally.
- Physical Therapy.
- Prescription Drugs and Medicines administered in the vein or muscle.
- Prosthetic Devices and Braces.
- Speech Therapy.

Benefit Maximums:

- 100 visits per Plan Year for home health services and outpatient hospice care.
- 21 visits per Plan Year for home skilled nursing.

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

See Also: *Notification Requirements and Care Coordination* section later in this *Medical Benefit Description*.

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, Wellmark determines whether to pay the rental amount or the purchase price amount for an item, and 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 later section of this *Medical Benefit Description* entitled *General Conditions of Coverage, Exclusions, and Limitations*.
- *Prosthetic Devices* later in this section.

Hospice Services

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

Commission for Accreditation of Health Care Organizations (JCAHO).

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

Benefit Maximums:
185 days per Plan Year for inpatient hospice care.
100 visits per Plan Year for outpatient hospice care and home health care.

Hospitals and Facilities

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

- Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.
- 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.
- 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.

Benefit Maximums:

- 60 days per Plan Year for skilled nursing services in a hospital or nursing facility.

See Also:

- *Chemical Dependency Treatment* earlier in this section.
- *Mental Health Services* later in this section.
- *Notification Requirements and Care Coordination* section later in this *Medical Benefit Description*.

Inhalation Therapy

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

Medical Benefit Description - Covered and Not Covered

Maternity Services

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

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

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

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

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

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 mandated Preventive Care and complications of pregnancy).

See Also: *Preventive Care* later in this section.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.
- Diabetic equipment and supplies including insulin syringes purchased from a covered home/durable medical equipment provider.

Not Covered: Elastic stockings or bandages including lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

- *Home/Durable Medical Equipment* earlier in this section.
- *Orthotics* later in this section.
- *Personal Convenience Items* in this section
- *Prosthetic Devices* later in this section.
- *General Conditions of Coverage, Exclusions, and Limitations* later in this *Medical Benefit Description*.

Medical Benefit Description - Covered and Not Covered

Mental Health Services

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

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 classified as a mental health condition in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised (DSM-IV-R) or subsequent revisions.
- The disorder is listed only as a mental health condition and not dually listed elsewhere in the most current version of International Classification of Diseases, Clinical Modification used for diagnosis coding.
- The disorder is not a chemical dependency condition.
- The disorder is a behavioral or psychological condition not attributable to a mental disorder that is the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered covered under your medical benefits.

Not Covered:

- Applied Behavior Analysis (ABA) services.
- Biofeedback.
- 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.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual Disorders.

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

Motor Vehicles

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

Musculoskeletal Treatment

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

Not Covered: Massage therapy.

Occupational Therapy

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

- Services are to treat the upper extremities, which means the arms from the shoulders to the fingers.
- The goal of the occupational therapy is improvement of an impairment or functional limitation.
- The potential for rehabilitation is significant in relation to the extent and duration of services.
- The expectation for improvement is in a reasonable (and generally predictable) period of time.
- There is evidence of improvement by successive objective measurements whenever possible.

Not Covered:

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

Orthotics

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

See Also:

- *Home/Durable Medical Equipment* earlier in this section.
- *Personal Convenience Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*.
- *Prosthetic Devices* later in this section.

Physical Therapy

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

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

Not Covered:

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

Physician and Other Health Practitioner Services

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

- Advanced Registered Nurse Practitioners (ARNP). An ARNP is a registered nurse with

advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role with a specialty designation of certified clinical nurse specialist, certified nurse midwife, certified nurse practitioner, or certified registered nurse anesthetist.
- Audiologists.
- Chiropractors.
- Doctors of Osteopathy (D.O.).
- Licensed Independent Social Workers.
- 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.

Benefit Maximums:
- 26 visits per Plan Year for chiropractic services.

See Also: *Choosing a Provider* section later in this *Medical Benefit Description***.**

Podiatry

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

Prescription Drugs

Covered:
- When you are an inpatient or outpatient of a facility.
- Any state sales tax associated with the purchase of a covered prescription drug.
- Prescription drugs and medicines covered under this medical benefits plan include:
  - Drugs and Biologicals. Drugs and biologicals approved by the U.S. Food and Drug Administration. This includes such supplies as serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.
  - Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).
  - Oral Chemotherapy Drugs.
  - Self-Administered Injectable Drugs. Self-administered injectable drugs are generally covered under this medical benefits plan.

Not Covered:
- Prescription drugs that are not FDA-approved.
- Insulin.

- Prescription drugs and devices used to treat nicotine dependence.
- Prescription drugs other than as stated earlier in this section.
- Glucose strips.
- Growth hormones.

See Also:
- *Contraceptives* earlier in this section.
- *Medical and Surgical Supplies* earlier in this section.
- *Notification Requirements and Care Coordination* later in this *Medical Benefit Description*.
- Separate *Prescription Drug Program* section of this SPD.

Preventive Care

Covered: Preventive care such as:
- Gynecological examinations.
- Mammograms.
- Medical evaluations and counseling for nicotine dependence per U.S. Preventive Services Task Force (USPSTF) guidelines.
- Pap smears.
- Physical examinations.
- Preventive items and services including, but not limited to:
  - Items or services with an "A" or "B" rating in the current recommendations of the USPSTF;
  - Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
  - Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
  - Preventive care and screenings for women provided for in guidelines supported by the HRSA.
- Well-child care including immunizations.

For more detailed information regarding Preventive Care, please see:
https://www.healthcare.gov/preventive-care-benefits/

Benefit Maximums:

- Well-child care until the child reaches age 17.
- One routine physical examination per Plan Year.
- One routine mammogram per Plan Year.
- One routine gynecological examination per Plan Year.

Not Covered: 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 Devices

Covered:

- Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.
- Braces, which are rigid or semi-rigid devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

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

See Also:

- *Home/Durable Medical Equipment* earlier in this section.
- *Medical and Surgical Supplies* earlier in this section.
- *Orthotics* earlier in this section.
- *Personal Convenience Items* in the later section *General Conditions of Coverage, Exclusions, and Limitations.*

Reconstructive Surgery

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

Breast reconstructive surgery includes the following:

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

See Also: *Cosmetic Services* earlier in this section.

Self-Help Programs

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

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

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

Speech Therapy

Covered: Rehabilitative speech therapy services when related to a specific illness, injury, or impairment and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.

Not Covered:

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

Surgery

Covered:

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

Not Covered: Cosmetic surgery.

See Also:

- *Cosmetic Services* earlier in this section.
- *Dental Services* earlier in this section.
- *Reconstructive Surgery* earlier in this section.

Temporomandibular Joint Disorder (TMD)

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 as described later in this Medical Benefit Description.

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

Benefit Maximums:

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

Not Covered:

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

See Also: *Notification Requirements and Care Coordination*, later in this *Medical Benefit Description*.
Travel or Lodging Costs
Not Covered
Vision Services
Covered: Vision examinations but only when related to an illness or injury, or well baby/well child screenings covered as part of Preventive Care.
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.
See Also: • *Preventive Care* earlier in this section. • Separate *Vision Care Benefits* section later in this SPD.
Weight Loss Services
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. • Any weight reduction or obesity-related surgery, including but not limited to panniculectomy or other body contouring procedures.
Wigs or Hairpieces
Not Covered
X-Ray and Laboratory Services
Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under Radiology Guidelines and Pathology and Laboratory Guidelines.
See Also: *Preventive Care* earlier in this section.

General Conditions of Medical 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 *Medical Benefit Description - 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, Wellmark reserves the right to approve the least costly alternative on behalf of the Plan.

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 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.

Eligibility for Coverage
Another general condition of coverage is that the person who receives services must be eligible and enrolled in coverage at the time of services.

General Exclusions
Even if a service, supply, device, or drug is listed as otherwise covered in *Medical Benefit Description - 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, Wellmark 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 setting.

General Conditions of Medical Coverage, Exclusions and Limitations

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

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.

See Also:
Clinical Trials.

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

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

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

General Conditions of Medical Coverage, Exclusions and Limitations

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

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

- You are entitled to claim benefits from a governmental program (other than Medicaid, Medicare or Tricare).

- Someone else has the legal obligation to pay for services or 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.

Benefit Limitations
Benefit limitations refer to amounts for which you are responsible under the 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 the Plan:

- A service or supply that is not covered under the Plan is your responsibility.

- If a covered service or supply reaches a benefit maximum, it is no longer eligible for benefits (a maximum may renew at the next Plan Year). See *Medical Benefit Description - Covered and Not Covered.*

- If you do not obtain precertification for certain medical services, benefits can be reduced or denied. You are responsible for benefit reductions if you receive the services from a nonparticipating

provider. You are responsible for benefit denials only if you are responsible (not your provider) for notification. A PPO provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*.

- If you do not obtain prior approval for certain medical services, benefits will be denied on the basis that you did not obtain prior approval. Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Claims and Appeal Procedures* section) and provide Wellmark with medical information for consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if Wellmark determines the service was medically necessary and a benefit under your medical benefits, benefits for that service will be provided according to the terms of your medical benefits.

  You are responsible for these benefit denials only if you are responsible (not your provider) for notification. A PPO provider in Iowa or South Dakota will handle notification requirements for you. If you see a PPO provider outside Iowa or South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*.

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

Choosing a Medical Provider

Your medical benefits are 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 PPO providers. These PPO providers offer services to members of contracting medical benefits plans at a reduced cost, which usually results in the least expense for you.

Non-PPO providers are either participating or nonparticipating. If you are unable to utilize a PPO provider, it is usually to your advantage to visit what Wellmark calls 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.

Please note: When you receive services from certain types of participating and nonparticipating providers, those services will be reimbursed as though they were received from a PPO provider. These providers are:

- Anesthesiologists
- Pathologists
- Radiologists

However, because the Plan does not have contracts with nonparticipating providers and they may not accept Wellmark's payment arrangements on behalf of the Plan, you will still be responsible for any difference between the billed charge and the Plan's settlement amount. See *Schedule of Medical Benefits* and *Factors Affecting What You Pay*.

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

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

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

Please note: Even though a facility may be PPO or participating, particular providers within the facility may not be PPO or participating providers. Examples include 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 the card, especially the ID number, is required to process your claims correctly.

Pharmacies do not participate with Alliance Select. Pharmacies typically do not provide services and supplies considered medical benefits under the Plan, and are not considered participating providers for such benefits.

Choosing a Medical Provider

Provider Comparison Chart	PPO	Participating	Nonparticipating
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	Yes	No
Minimizes your payment obligations. See *Schedule of Medical Benefits*.	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* below.

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.

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

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

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

  If you purchase or rent home/durable medical equipment and have that equipment shipped to a service area of a Blue Cross and/or Blue Shield Plan that does not have a contractual relationship with the home/durable medical equipment provider, that provider will be considered nonparticipating and you will be responsible for any applicable nonparticipating provider payment obligations and you may also be responsible for any difference between the amount charged and the amount paid for the covered service. This includes situations where you purchase or rent home/durable medical

equipment and have the equipment shipped to you in Wellmark's service area, when Wellmark does not have a contractual relationship with the home/durable medical equipment provider.

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

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

Talk to your provider
Whenever possible, before receiving laboratory services, home/durable medical equipment, orthotics, or prosthetic devices, ask your provider to utilize a provider that has a contractual arrangement with the Blue Cross and/or Blue Shield Plan where you received services, purchased or rented equipment, or shipped equipment, or ask your provider to utilize a provider that has a contractual arrangement with Wellmark.

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

BlueCard Program
Wellmark has relationships with other Blue Cross and Blue Shield Plans. These relationships are generally referred to as Inter-Plan Programs. Whenever you obtain services outside Iowa or South Dakota, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program. These programs ensure that members of any Blue Cross and/or Blue Shield Plan have access to the advantages of PPO providers throughout the United States. Participating providers have a contractual agreement with the Blue Cross or Blue Shield Plan in their home state ("Host Blue"). The Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within the Wellmark 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.

Typically, 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*. However, if you are admitted to a BlueCard facility outside the Wellmark service area, any BlueCard provider will handle notification requirements for you.

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.

Medical Benefits:
Notification Requirements and Care Coordination

Many services require a notification to Wellmark or a review by Wellmark. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical. For a complete list of services subject to notification or review, visit Wellmark.com or call the Customer Service number on your ID card.

BlueCard Providers and Notification Requirements
Typically, only BlueCard providers in Iowa and South Dakota handle notification requirements for you. However, if you are admitted to a BlueCard facility outside Iowa or South Dakota, any BlueCard provider will handle notification requirements for you.

If you receive any other covered services (i.e., services unrelated to an inpatient admission) from a BlueCard provider outside Iowa or South Dakota, you or someone acting on your behalf is responsible for notification requirements.

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

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Claims and Appeal Procedures* and *Authorized Representative*.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. Precertification is required; however, it does not apply to maternity or emergency services.
Applies to	For a complete list of the services subject to precertification, visit Wellmark.com or call the Customer Service number on your ID card.
Person Responsible	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 precertification if: • You receive services subject to precertification (other than services you receive as an inpatient in a facility) from a provider outside Iowa or South Dakota; • You receive services subject to precertification from a participating or nonparticipating provider.

Medical Benefits:
Notification Requirements and Care Coordination

Precertification

Process	When you, instead of your provider, are responsible for precertification, call the Customer Service number on your ID card before receiving services. Wellmark will respond to a precertification request within: • 72 hours in a medically urgent situation; or • 15 days in a non-medically urgent situation. Precertification requests must include supporting clinical information to determine medical necessity of the service or admission. After you receive the service(s), Wellmark may review the related medical records to confirm the records document the services subject to the approved precertification request. The medical records also must support the level of service billed and document that the services have been provided by the appropriate personnel with the appropriate level of supervision.
Importance	If you choose to receive services subject to precertification and Wellmark determines that the procedure was not medically necessary, you will be responsible for the charges. If you receive the services from a nonparticipating provider and Wellmark determines the procedure is medically necessary and otherwise covered, without precertification, benefits can be reduced by 100% of the maximum allowable fee, after which Wellmark subtracts your applicable payment obligations. The maximum reduction will not exceed $200 per admission. See *Maximum Allowable Fee*. You are subject to this benefit reduction only if you receive the services from a nonparticipating provider. Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *Schedule of Medical Benefits*.

Notification

Purpose	Notification of most facility admissions and certain services helps Wellmark identify and initiate discharge planning or care coordination. Notification is required.
Applies to	For a complete list of the services subject to notification, visit Wellmark.com or call the Customer Service number on your ID card.

Medical Benefits:
Notification Requirements and Care Coordination

Notification

Person Responsible	PPO providers in the states of Iowa and South Dakota perform notification for you. However, you or someone acting on your behalf are responsible for notification if: • You receive services subject to notification (other than services you receive as an inpatient in a facility) from a provider outside Iowa or South Dakota; • You receive services subject to notification from a participating or nonparticipating provider.
Process	When you, instead of your provider, are responsible for notification, call the Customer Service number on your ID card before receiving services, except when you are unable to do so due to a medical emergency. In the case of an emergency admission, you must notify Wellmark within one business day of the admission or the receipt of services.

Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical benefits. Prior approval is required.
Applies to	For a complete list of the services subject to prior approval, visit Wellmark.com or call the Customer Service number on your ID card.
Person Responsible	PPO providers in the states of Iowa and South Dakota request prior approval for you. You are responsible for prior approval if: ▪ You are admitted to a facility outside Iowa or South Dakota; ▪ You receive services subject to prior approval from a provider outside Iowa or South Dakota; ▪ You receive services subject to prior approval from a participating or nonparticipating provider.

Medical Benefits:
Notification Requirements and Care Coordination

Prior Approval

Process

When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.

Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to it. Wellmark will respond to a prior approval request in writing to you and your provider within:

- 72 hours in a medically urgent situation; or
- 15 days in a non-medically urgent situation.

Prior approval requests must include supporting clinical information to determine medical necessity of the services or supplies.

Importance

If your request is approved, the service is covered provided other contractual requirements, such as eligibility and benefit maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial.

If you do not request prior approval for a service, the benefit for that service will be denied on the basis that you did not request prior approval.

Upon receiving an Explanation of Benefits (EOB) indicating a denial of benefits for failure to request prior approval, you will have the opportunity to appeal (see the *Claims and Appeal Procedures* section) and provide Wellmark with medical information for consideration in determining whether the services were medically necessary and a benefit under your medical benefits. Upon review, if Wellmark determines the service was medically necessary and a benefit under your medical benefits, the benefit for that service will be provided according to the terms of your medical benefits.

Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits in effect and the information Wellmark had as of the approval date. If your coverage changes for any reason (for example, because of a new job or new medical benefits), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.

Note: When prior approval is required, and an admission to a facility is required for that service, the admission also may be subject to notification or precertification. See *Precertification* and *Notification* earlier in this section.

Medical Benefits:
Notification Requirements and Care Coordination

Concurrent Review

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

Case Management

Purpose	Case management is a process of considering alternative treatments for Covered Persons 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.
Applies to	Examples where case management might be appropriate include but are not limited to: • Brain or Spinal Cord Injuries • Cystic Fibrosis • Degenerative Muscle Disorders • Hemophilia • Home Health Services • Pregnancy (high risk) • Transplants

Medical Benefits:
Notification Requirements and Care Coordination

Case Management

Person Responsible	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. You may request additional information regarding case management by calling the Customer Service number on your ID card or, by visiting Wellmark.com.
Process	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. 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. 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.
Importance	Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.

Factors Affecting What You Pay for Medical Care

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

Plan Year
A Plan Year is the same as a calendar year, January 1 through December 31. Your Plan Year continues even if the Board of Trustees changes group health plan benefits during the year.

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

The Plan Year is important for calculating:

- Deductible.
- Coinsurance.
- Out-of-pocket maximum.
- Benefit 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
Coinsurance is calculated using the payment arrangement amount after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions.

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 negotiated price that the Host Blue makes available to Wellmark after the following amounts (if applicable) are subtracted from it:

    - Deductible.
    - Certain copayments.
    - Amounts representing any general exclusions and conditions..

    Often, the negotiated price will be a simple discount that reflects an actual price the local Host Blue paid to your provider. Sometimes, the negotiated price is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges.

Occasionally, the negotiated price may be an average price based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or under-estimation of modifications of past pricing for the types of transaction modifications noted previously. However, such adjustments will not affect the price Wellmark uses for your claim because they will not be applied retroactively to claims already paid.

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

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions.

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

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

- The PPO payment obligation amounts may be waived or may be less than the participating and nonparticipating amounts for certain covered services. See *Waived Payment Obligations*.

- 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 for the Plan. Pharmacies are considered nonparticipating providers. Therefore, when you receive services from nonparticipating providers:

- You are responsible for any difference between the amount charged and the Plan's payment for a covered service. In the case of services received outside Iowa or South Dakota, the Plan's maximum payment for services by a nonparticipating provider will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In certain situations, Wellmark may use other payment bases, such as the amount charged for a covered service, the payment Wellmark would make if the services had been obtained within Iowa or South Dakota, or a special negotiated payment, as permitted under Inter-Plan Programs policies, to

determine the amount the Plan will pay for services you receive from nonparticipating providers. See *Services Outside the Wellmark Service Area*.

- 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 your medical benefits.

Maximum Allowable Fee

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

Payment Arrangements

Payment Arrangement Savings

Wellmark has contracting relationships with PPO providers. Wellmark uses different methods to determine payment arrangements for the Plan, 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 saved on a claim. However, depending on many factors, the amount the Plan pays a provider could be different from the covered charge. Regardless of the amount the Plan pays a participating or PPO provider, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.

- *Amount Not Covered*, which reflects the portion of provider charges not covered under your health benefits and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a benefit maximum, Plan Year maximum, or lifetime benefits maximum; reductions or denials for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*.

- *Amount Paid by Health Plan*, which reflects the Plan's payment responsibility to a provider or to you. Wellmark determines this amount by subtracting the following amounts (if applicable) from the amount charged:

- Deductible.
- Coinsurance.
- Copayment.
- Amounts representing any general exclusions and conditions.
- Network savings.

Payment Method for Services
Wellmark calculates provider payment arrangements on behalf of the Plan using industry methods, including but not limited to fee schedules, per diems, percentage of charge, capitation, or episodes of care. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to the Plan or to your specific claims and are not considered when determining any amounts you may owe. Wellmark reserves the right to change the methodology it uses to calculate payment arrangements based on industry practice or business need.

PPO and participating providers agree to accept Wellmark's payment arrangements on behalf of the Plan as full settlement for providing covered services, except to the extent of any amounts you may owe.

Wellmark Drug List
Most prescription drugs are covered under a separate drug program offered by the Plan, and not under your medical benefits. This program is described in the *Prescription Drug Program* section of this SPD.

Information about the Wellmark Drug List and rebates from drug manufacturers applies only to those drugs (such as injectable drugs) that may be covered under your medical benefits.

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List contains drugs physicians recognize as medically effective for a wide range of health conditions.

The Wellmark Drug List was developed with the assistance of physicians, pharmacists, and Wellmark's pharmacy benefits manager. It is not a required list of medications and physicians are not limited to prescribing only the drugs that appear on the list. Physicians may prescribe any medication, and that medication will be covered unless it is specifically excluded under your medical benefits, or other limitations apply.

To determine if a drug is on the Wellmark Drug List, visit Wellmark.com.

The Wellmark Drug List is subject to change.

Pharmacy Benefits Manager Fees and Drug Company Rebates
Wellmark contracts with a pharmacy benefits manager to provide pharmacy benefits management services. Drug manufacturers offer rebates to pharmacy benefits managers. After your group has had Wellmark health coverage for at least nine months, the pharmacy benefits manager contracting with Wellmark will calculate, on a quarterly basis, your group's use of drugs for which rebates have been paid. Wellmark receives these rebates. Your group will be credited with rebate amounts forwarded to Wellmark by the pharmacy benefits manager. Wellmark will not distribute these rebate amounts to you, and rebates will not be considered when determining your payment obligations.

Factors Affecting What You Pay for Medical Care

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.

Value-Based Programs
Value-based programs involve local health care organizations that are held accountable for the quality and cost of care delivered to a defined population. Value-based programs can include accountable care organizations (ACOs), patient centered medical homes (PCMHs), and other programs developed by Wellmark, Blue Cross Blue Shield Association, or other Blue Cross Blue Shield health plans ("Blue Plans"). Wellmark and Blue Plans have entered into collaborative arrangements with value-based programs under which the health care providers participating in them are eligible for financial incentives relating to quality and cost-effective care of Wellmark members. Your claims information may be used by the value-based program and any providers involved in such value-based program.

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Medical Benefit Definitions

The definitions in this section are terms that are used in this *Medical Benefit Description* section of this SPD.

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 the Plan.

Benefits. Medically necessary services or supplies that qualify for payment under the 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.

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 individual seeking services or, in the opinion of a physician with knowledge of the individual's medical condition, would subject the individual to severe pain that cannot be managed without the services in question.

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 the outpatient department of a hospital, an ambulatory surgery center, or the home.

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

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 medical benefit description, that may be used to diagnose or treat a medical condition.

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*.

Prescription Drug Program

Prescription Drug Program
Schedule of Benefits

Preventive Care Items and Services		
	You Pay	Plan Pays
As defined by the Affordable Care Act	0%	100%
Retail Pharmacy Option Limited to a 30-day supply		
	You Pay	Plan Pays
Generic drugs	20%	80%
Brand Name drugs	30%	70%
Brand Name drugs with a Generic equivalent	40%	60%
Mail Order Prescription Drug Option Limited to a 90-day supply Available for maintenance drugs. Maintenance drugs are those taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.		
	You Pay	Plan Pays
Generic drugs	20%	80%
Brand Name drugs	30%	70%
Brand Name drugs with a Generic equivalent	40%	60%
Maximum Out-Of-Pocket Amount **Per Plan Year For Prescription Drug Expenses**		
The Maximum Out-of-Pocket Amount is the maximum amount paid by the Covered Person in the Plan Year. Charges for non-covered expenses and charges in excess of the discounted network price do not calculate toward the Out-of-Pocket Amount. This maximum is separate from the maximum that applies to the medical benefit portion of the Plan. Your prescription coinsurance is not eligible for reimbursement under the medical benefit portion of the Plan, but may be covered by the Participant's HRA. See separate *HRA Benefits* section of this SPD.		
Per Person Beginning 1/1/2015	$3,600	
Per Family Unit Beginning 1/1/2015	$7,200	
The Plan will pay its share of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		

Prescription Drug Program
Covered Items and Services

The Plan will pay the percentage of the discounted network price shown in the Schedule of Benefits for each prescription and each refill of a prescription. Prescribed drugs are covered only for treatment of an illness or injury, except as otherwise indicated below. As described in more detail below, certain prescription drugs may require a Prior Authorization (described later in this section) to receive the prescription or full quantity that your doctor prescribes. As also described further below, drugs that are excluded from the Express Scripts National Preferred Formulary are not covered, unless you and your doctor obtain a clinical exception from Express Scripts.

For purposes of this section, "OTC" refers to products that are available over-the-counter and without a prescription.

Preventive Care items and services include:

- Aspirin for cardiovascular disease, generic only, OTC, products ≤ 325 mg, for men ages 45 through 79 and women ages 55 through 79.
- Aspirin for preeclampsia, generic only, OTC, products ≤ 81 mg, for women under age 55.
- Bowel preparation agents, generic only, for adults ages 49 through 76. Limited to two prescriptions per Plan Year.
- Breast cancer drugs, generic only (e.g. tamoxifen), for prevention of breast cancer, for women aged 35 and over.
- Fluoride, generic only, for children ages 6 months through 5 years.
- Folic acid, generic only, products 0.4-0.8 mg, for women through age 50.
- Iron supplements, generic only, for children age 6 months through 12 months.
- Smoking cessation, all FDA-approved products, for adults ages 18 and over. Limited to two 90 day treatment regimens per Plan Year.
- Vaccines for immunizations, within age and gender restrictions provided by the Affordable Care Act.
- Vitamin D (D2 or D3, 1,000 IUs or less, includes products combined with calcium), generic only, with prescription, for adults age 65 and over.
- Women's contraceptives, including hormonal contraceptives (oral, transdermal, intravaginal ring and injectable); barrier contraceptives (diaphragms and cervical caps); emergency contraceptives; implantable contraceptive medications; intrauterine contraceptives; and OTC barrier methods (female condom, spermicides, sponge) with a prescription. Multi-Source brand contraceptives require a prior authorization (see *Prior Authorizations* section below).

Other covered items and services include:

- Drugs prescribed by a Physician that require a prescription either by federal or state law, except as specifically excluded under the Plan.
- Insulin and other diabetic supplies (i.e., glucometers, insulin needles and syringes, insulin pump needles, lancets, and lancet devices, test strips and tapes).
- Inhaler assisting devices.
- Prenatal vitamins.
- Children's vitamins with fluoride (to age 15).
- Topical Tretinoin (e.g., Retin-A) through age 30; over age 30 with Prior Authorization.

Prescription Drug Program
Covered Items and Services

As new drugs are developed and released, and as treatment protocols change, the lists below for Prior Authorizations and Formulary drugs may change. For changes after the publication date of this SPD, go to www.Express-Scripts.com or call the Member Services number on your ID card.

Prior Authorization

Your prescription drug program provides coverage for some drugs only if they are prescribed for certain uses, durations, or quantities. For this reason, some drugs must receive authorization before they can be covered under your benefit plan. If the drug you have been prescribed must be pre-authorized, your pharmacist will tell you. You may ask that your pharmacist contact your physician to request that he or she initiate a review. It may shorten the review time, however, if you contact your physician directly and request that he or she call Express Scripts at the Pharmacy Help Desk number on your ID card to initiate the review, which typically takes two business days. The patient and physician will be notified when the review is complete. If your medication is not approved for coverage under the Plan, you will have to pay the full cost of the drug. You may appeal the decision. For more information on appeals, call Member Services at the number on your ID card.

The following drugs are covered, but only subject to Prior Authorization.

These include many specialty drugs, which are prescription medications that require special handling, administration or monitoring. Specialty drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

Afinitor	Iressa	Sprycel
Bosulf	IVIG's Kadcyla	Stivarga
Copaxone	Juxtapid	Synagis
Daklinza	Kalydeco	Tafinlar
Drugs for Treatment of Erectile Dysfunction, BPH or other appropriate conditions (e.g., Viagra, Cialis, Levitra, etc.)	Leuprolide	Tarceva
	Lynparza	Tasigna
	Mekinist	Testosterone, both injectable and topical
	Multi-Source Brand Contraceptives	Topical Tazarotene
Egrifta	Olyssio	Topical Tretinoin for adults age 30 and over
Enbrel	Orkambi	Tykerb
Erbilux-Vectibix	Pegasys, Pegintron	Viekira
Gilotrif	Perjeta	Xaikori
Gleevec	Prolia	Zelboraf
Growth hormones	Reclast/Boniva	Zykadia
Harvoni	Repatha	
Herceptin	Ribavirin	
Hepatitis Injections	SCIG	
H.P. Acther Gel	Selzentry	
Ibrance	Solvaldi	
Iclusig		

Prescription Drug Program
Covered Items and Services

The Natural Preferred Formulary

Your prescription drug program utilizes the Express Scripts National Preferred Formulary (NPF), which is the most widely used drug list in the United States. A formulary is a list of commonly prescribed medications that are preferred based on their clinical effectiveness and/or lower plan cost. Out of more than 3,900 drugs available on the market today, only 85 are excluded from the NPF. Medications are excluded only when clinically equivalent alternatives are already covered on the NPF, and only when those exclusions will result in significant cost savings for health plans and plan Participants and covered dependents.

The excluded medications shown below are not covered on the NPF. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for a preferred alternative. If you have rare clinical needs that require your continued use of a medication excluded below, your physician directly and request that he or she call Express Scripts at the Pharmacy Help Desk number on your ID card to initiate the review

NPF Excluded Medications/Products at a Glance		
Abbott (FreeStyle, Precision)	Follistim AQ	ribasphere ribapak
Abstral	Fortesta Ganirelix Acetate	RibaTab
Acuvail	Gel-One	Roche (Accu-Chek)Saizen
ADV MED TECH	Genvisc 850	Simponi 50 MG
(TRUEtest, TRUEtrack)	Glumetza	Sovaldi
Advocate	Hyalgan	Staxyn
Alogliptin	Hymovis	Stendra
Alogliptin/Metformin	Istalol	Subsys
Alvesco	Kazano	Supartz
Apidra	Kineret (Exclude for RA)	Supartz FX
Aranesp	Kombiglyze XR	Synvisc
Asacol HD	Levitra	Synvisc-One
Bayer (Breeze, Contour)	Mircera	Taltz
Beconase AQ	Natesto	Tanzeum
Bravelle	Nesina	Testim
Cetraxal	Novolin	Testosterone Gel
Cimzia	NovoLog	Ultresa
Colchicine	Nutropin AQ	UniStrip
Daklinza	Olysio	Veltin
Delzicol	Omnaris	Veramyst
Dipentum	Omnis Health	Victoza
Doxycycline 40 MG Capsules	(Embrace, Victory)	Vimovo
Duexis	Omnitrope	Vogelxo
Endometrin	Onglyza	Xopenex HFA
Epogen	Orencia	Zepatier
Estrogel	Pancreaze	Zetonna
Evzio	Pertzye	Zioptan
Fentora	Proventil HFA	Zomacton
Fluorouracil 0.5% Cream	Qsymia	Zyclara

Prescription Drug Program
Limitations and Exclusions

No benefits are payable under this program for:

- Drugs that do not require a written prescription of a licensed Physician, except as otherwise specified above.
- Drugs dispensed from or by any Hospital, Extended Care Facility, clinic, or other institution to an Inpatient or Outpatient or as "take-home" drugs following confinement (see the Medical Benefits section of this SPD).
- Drugs dispensed by other than a retail or mail order pharmacy.
- Charges for prescriptions that exceed the 30 day retail or 90 day mail order supply requirements.
- Injectables with the exception of insulin, Imitrex and EpiPen and injectables listed under drugs requiring Prior Authorization.
- Any charge for the administration of a covered Prescription Drug, except for immunizations.
- Any charges for anabolic steroids.
- Any charge for appetite suppressants, anorexiants, or dietary supplements.
- Charges for the compounding of any drug that are in addition to negotiated fees.
- Any charge for cosmetic products, except as specifically listed as covered.
- A charge for any devices or appliances, except as specifically outlined above. (See Medical Benefits section of this SPD for possible coverage.)
- Any drug not approved by the United States Food and Drug Administration.
- Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- Charges for Minoxidil, Rogaine or similar drug for promotion of hair growth.
- Charges for infertility drugs.
- Drugs purchased via the Internet or from a foreign country.
- Any drug or medicine labeled: "Caution – limited by federal law to investigational use," or any drug that is experimental.
- Charges for refills of a prescription that is more than one year old.
- Drugs to treat sexual dysfunction, except as specified above.
- Charges for syringes and needles, except in conjunction with the administration of insulin.
- Nutritional supplements or vitamins, except as specified above.
- Drugs prescribed by a Close Relative.
- Biological sera, blood or blood plasma, or products derived from blood or blood products.
- Topical fluoride, except as otherwise specifically provided in this Prescription Drug Program section.
- Prior Authorization drugs for which authorization is not received and drugs excluded from the National Preferred Formulary, unless a clinical exception is obtained.

HRA Benefits

HRA Benefits

HRA Benefits Purpose
The purpose of the HRA Benefits is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and dependents' Health Care Expenses that are not reimbursable from other sources. Reimbursements for Health Care Expenses paid by the HRA generally are excludable from taxable income.

HRA Benefits
Once you become a Participant, the Plan will maintain an HRA in your name to keep a record of the amounts available to you for the reimbursement of eligible Health Care Expenses. Your HRA is funded by contributions made by Contributing Employers. Some of those contributions are allocated as "premiums" for the other welfare benefits offered by the Plan, and your HRA is reduced monthly for those premium amounts. Whatever remains in your HRA after premium payments is available for reimbursement of Health Care Expenses that are not payable from the medical, dental or vision programs or any secondary source of health coverage. Those amounts are also available to cover periods when you would be subject to self-payment of contributions, as described in the *Eligibility and Participation* section of this SPD.

After the end of the Plan Year, the unused amount (if any) in your HRA generally will remain available in the next Plan Year, provided you are still a Participant (and subject to any election you may make to suspend or opt out of participation in the HRA).

HRA Claims
The HRA will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA. Benefits must first be reimbursed from the medical, dental or vision benefit programs and any secondary health insurance coverage before any benefits are payable from the HRA. The following procedure should be followed:

- You must submit a claim to the Administrative Manager and provide any additional information requested by the Administrative Manager;

- A request for payment must relate to Health Care Expenses incurred by you, your Spouse, or your dependent(s) during the time you were a Participant under the Plan; and

- You must provide an Explanation of Benefits (EOB) for reimbursements made by other medical, dental or vision plan coverage.

  Claims must be submitted in writing. The Administrative Manager may require that Participants submit claims on a form provided by the Administrative Manager. The claim must set forth—

- The individual(s) on whose behalf the Health Care Expenses were incurred;

- The nature and date of the Health Care Expenses so incurred;

- The amount of the requested reimbursement; and

- A statement that such Health Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Health Care Expenses have been incurred and showing the amounts of such Health Care Expenses, along with any additional documentation that the

Administrative Manager may request (including, but not limited to, proof of a prescription). Generally, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $100, although there is an exception made for the final reimbursement claim for a Plan Year.

Health Care Expenses
Only Health Care Expenses are covered by the HRA. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether or not the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment. The Administrative Manager can provide you with more information about which expenses are eligible for reimbursement.

HRA Limitations and Exclusions
Some examples of expenses that are not Health Care Expenses and are not eligible for reimbursement include the following:

- Pregnancy testing kits.
- Effective January 1, 2011, OTC drugs or medicines that are purchased without a prescription. This exclusion does not apply to insulin, diabetic testing and supplies or to OTC drugs prescribed by a physician.
- Health insurance premiums for any other plan maintained outside the Plan.
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to a Participant's, Spouse's, or dependent's inability to perform physical housework).
- Massage therapy.
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Health club or fitness program dues, even if the program is necessary to alleviate a specific medical condition such as obesity.

- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code §213.
- Any expense incurred before you became a Participant.

HRA Maximum
Any balance remaining in the Participant's account at the end of the Plan Year will be rolled over to the next year to be used for recognized HRA withdrawals. There is no limit on the dollar amount accumulated in the HRA.

HRA Opt-Out
To satisfy the Affordable Care Act's requirements to keep your HRA benefit "integrated" with your medical benefit, you may elect to permanently opt out of and waive any right to reimbursements from your HRA by completing an opt-out form during each annual open enrollment that will take effect as of the beginning of the next Plan Year (January 1). In addition, a one-time opt-out of the HRA benefit is available upon the occurrence of any of the following events: (1) your termination of employment or other loss of eligibility; (2) your becoming eligible for retiree coverage or (3) your death (for your surviving dependents).

If you elect to opt-out of your HRA, any amounts remaining in your account will be forfeited and will not be reinstated in the event you subsequently elect to re-enroll in the HRA benefit. Opting out of HRA coverage is generally advantageous only to individuals who wish to enroll in individual medical insurance coverage, including that offered through the government insurance Marketplace. If you wish to explore this option or obtain an "opt-out" form, please contact the Administrative Manager.

Dental Benefits

Schedule of Dental Benefits
Dental Payment Information
Covered Dental Charges
Dental Limitations and Exclusions
Dental Notification Program

Schedule of Dental Benefits

Schedule of Dental Benefits	
Deductible, per Plan Year	
Per Covered Person	$50
Dental Percentage Payable by Plan	
Class I - Diagnostic & Preventive Services (Check-ups and Teeth Cleaning)	80% Deductible waived
Class II - Routine and Restorative Services, Endodontic Services and Periodontal Services (Cavity Repair and Tooth Extractions, Root Canals and Treatment of Gum and Bone Diseases)	80% after Deductible
Class III - High Cost Restoration Services and Prosthetics (Cast Restorations, Dentures and Bridges)	80% after Deductible
Class IV - Orthodontia (Services to Straighten Teeth)	50% after Deductible
Maximum Benefit Amount per Plan Year	
Covered Persons Under Age 18 Class I Services Class II and III Services Combined Covered Persons Age 18 and Over Classes I, II and III Services Combined	 Unlimited $1,500 $1,500
Maximum Benefit Amount per Lifetime for Class IV Services	$2,000

Dental Payment Information

Delta Dental Network - What You Should Know About Selecting a Dentist

You may seek care from almost any dentist you wish. However, there are usually advantages when you receive services from participating Delta Dental Dentists.

Your payment responsibilities are also outlined in this section of the SPD. How much you pay for Covered Services depends on the benefit category of the service you receive and the dentist you receive services from. It is most often to your financial advantage to receive services from a Delta Dental Dentist.

What You Should Know About Delta Dental Dentists

Delta Dental has contracted relationships with Delta Dental Dentists throughout the state. Their contracts with Delta Dental Dentists include payment arrangements that are made possible by their broad base of customers. Delta Dental uses different methods to determine payment arrangements. These payment arrangements usually result in savings to you. When you receive services from Delta Dental Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

- Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangements, which may result in savings.
- Delta Dental Dentists agree to file claims for you.
- Delta Dental settles claims directly with Delta Dental Dentists. You are responsible for any deductible and coinsurance amounts you may owe. See *Understanding Amounts You Pay To Share Costs* later in this section.
- Delta Dental Dentists agree to handle the notification program for you. See *The Notification Program* section.
- Delta Dental Dentists agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Services. **Important**: This does not apply in the situation where a service otherwise qualifying as a Covered Service is provided and Delta Dental does not reimburse any part of such service. In such situation, the Delta Dental Dentist is not limited in the amount of the payment he or she may collect from you. See *Understanding Payment Vocabulary* later in this section.

What You Should Know About Dentists Who Do Not Participate With Delta Dental

When you receive services from nonparticipating (non-par) dentists, you will not receive any of the advantages that Delta Dental's contracts with Delta Dental Dentists offer. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- Delta Dental does not have contracting relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental Member Company's payment arrangements. This means you are responsible for any difference between your nonparticipating dentist's billed charge and the Maximum Plan Allowance. See *Understanding Payment Vocabulary* later in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- Delta Dental settles claims with you, not nonparticipating dentists. You are responsible for paying your dentist in full, including any deductible, coinsurance and non-approved charges you may owe. See *Understanding Payment Vocabulary* later in this section.
- Nonparticipating dentists do not agree to handle the notification program for you. See *The Notification Program* section.

Dental Payment Information

- Nonparticipating dentists may charge for "infection control," which includes the costs for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a nonparticipating dentist for "infection control." (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, Delta Dental Dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) Delta Dental's Maximum Plan Allowance for Covered Services, as do Delta Dental Dentists in certain situations. See *Understanding Payment Vocabulary* later in this section.

Dental Payment Information

Questions the Dental Claims Administrator Asks When You Receive Dental Care

Even though a procedure may appear in a given section, such as *Covered Dental Charges*, you should note that before you are eligible to receive benefits, the Dental Claims Administrator first answers all of the following questions:

Is the Procedure Dentally Necessary?

All of the following must be true for a procedure to be considered dentally necessary:

- The diagnosis is proper; and
- The treatment is necessary to preserve or restore the basic form and function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the Procedure Dentally Appropriate?

All of the following must be true for a procedure to be considered dentally appropriate:

- The treatment is the most appropriate procedure for your individual circumstances; and
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us; and
- The treatment is not more costly than alternative procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. ***If you receive services which are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.***

Is the Procedure Subject to Plan Limitations?

Plan limitations refer to amounts that are your responsibility based on the design of your Plan. Examples of Plan limitations include all of the following:

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this dental benefit portion of the Plan. See *Dental Limitations and Exclusions*.
- Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered twice per Plan Year. More frequent teeth cleaning is not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See *Covered Dental Charges* for a description of covered procedures and limitations associated with certain procedures.
- Amounts for procedures that have reached Plan maximums. See the *Schedule of Dental Benefits* at the beginning of this section.
- Any difference between the dentist's billed charge and the Maximum Plan Allowance, as the case may be. (Please note: This only applies if you receive services from a nonparticipating dentist.)
- Deductible(s) and Coinsurance.

Dental Payment Information

Understanding Payment Vocabulary

Billed Charge
The billed charge is the amount a dentist bills for a specific dental procedure.

Covered Dental Charge
The covered dental charge is the amount a dentist bills for a dentally necessary and appropriate dental procedure, subject to the Maximum Plan Allowance, as listed in the *Covered Dental Charges* section that appears later in this part of the SPD.

Date Charges Are Incurred
A dental charge is incurred on the date the service is performed or the date the dental appliance or material is furnished.

Delta Dental's Payment Policy
Delta Dental's policy is to send payment for treatment after it is completed—not before.

For example, Delta Dental will send payment for:
- A crown when it is seated.
- A fixed or removable prosthesis when it is inserted.
- A root canal when it is filled.

Delta Dental Member Company
Delta Dental Member Company means a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Associations Bylaws.

Maximum Plan Allowance
Maximum Plan Allowance is the amount which Delta Dental establishes as the maximum allowable fee for the dental services under the Plan. For services billed by dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company. The Maximum Plan Allowance is established by Delta Dental for dental services contained in the "Current Dental Terminology" published by the American Dental Association from time to time. It is developed from various sources that may include, but are not limited to, contracts with dentists, the simplicity or complexity of the procedure, the billed charge for the same procedure by dentists in the same geographic area and with similar training and skills, and a leading economic indicator, such as the Consumer Price Index.

Plan Year
A Plan Year is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage. The Plan Year is important for calculating your deductible and Plan maximums.

Treatment in Progress When Eligibility Terminates
The Plan will generally not pay for services and supplies furnished after the date a Covered Person's eligibility terminates.

The Plan will pay for services or supplies related to the following treatments if the treatment is rendered during the calendar month immediately after the eligibility termination date and the respective conditions are met:

- A prosthetic device (such as full or partial dentures) if the dentist took the impressions and prepared the abutment teeth while the individual was a Covered Person under the Plan;
- A crown if the dentist prepared the affected tooth for the crown while the individual was a Covered Person under the Plan;
- Root canal therapy if the dentist opened the affected tooth while the individual was a Covered Person under the Plan.

Understanding Amounts You Pay To Share Costs

Benefit Payment
Each Plan Year, benefits will be paid to a Covered Person for Covered Dental Charges after the Deductible amount has been satisfied, if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the *Schedule of Dental Benefits* at the beginning of this section of the SPD. No benefits will be paid in excess of the Maximum Benefit Amount.

If an individual is covered by both the Medical Benefits and Dental Benefits available under this Plan, Medical Benefits shall be paid prior to Dental Benefits, if applicable, and benefits will not be coordinated between the two sets of benefits.

Deductible
Deductible is the fixed dollar amount you pay for Covered Services for each Covered Person in a Plan Year before certain benefits are available under the dental portion of the Plan. This amount is shown on the *Schedule of Dental Benefits* at the beginning of this section of the SPD.

Coinsurance
Coinsurance is the Dental Percentage Payable by the Plan each time you receive certain Covered Services. These amounts are shown on the *Schedule of Dental Benefits* at the beginning of this section of the SPD. Coinsurance payments begin once you meet any applicable deductible amounts. In general, the percentage of coinsurance you pay depends on the benefit category of the service you receive.

Deductible Amount
This is an amount of dental charges for which no benefits will be paid. Before benefits are paid in a Plan Year, a Covered Person must meet the Deductible shown in the *Schedule of Dental Benefits*.

Maximum Benefit Amount
The Maximum Benefit Amount is shown in the *Schedule of Dental Benefits*. All payments under for dental benefits are limited to the Maximum Benefit Amount shown in the *Schedule of Dental Benefits* for the category of care involved. The Maximum Benefit Amount applies to the Participant and each of his or her eligible dependents separately.

The Maximum Benefit Amount of Orthodontic Services is determined on a Lifetime basis. It is not renewed if eligibility is lost and then reinstated at a later date. The Maximum Benefit Amount for all other covered expenses applies to payment for treatment each Plan Year and so is renewed each January 1. Benefits not used in a prior year cannot be carried forward to increase the Maximum Benefit Amount for the next Plan Year.

Covered Dental Charges

The Plan pays benefits for the Covered Dental Charges made by a dentist or other Physician for the dentally necessary and appropriate services as follows:

CLASS I Dental Benefits - Diagnostic and Preventive Services (Check-ups and Teeth Cleaning)

- Dental cleaning (prophylaxis) for removing plaque, tartar (calculus), and stain from the teeth. *Limited to twice per Plan Year.*
- Routine oral exams. *Limited to twice per Plan Year.*
- Bitewing x-rays. *Limited to twice per Plan Year (except when taken as a series of full-mouth x-rays, below).*
- Occlusal x-rays, extraoral x-rays or periapical x-rays (radiographic images of a tooth or limited number of teeth that includes the crown and root portions).
- Full-mouth x-rays - Either (a) a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date; or (b) a panoramic x-ray. *Limited to once every 3 consecutive years.*
- Topical fluoride applications. *Limited to Covered Persons under age 19, once per Plan Year.*
- Sealant applications - Sealing the surface of molars to prevent decay. *Limited to Covered Persons under age 15, once per permanent and second molars per lifetime.*
- Space maintainers for missing back teeth: *Limited to Covered Persons under age 19.*

CLASS II Dental Benefits - Routine and Restorative Services

Cavity Repair and Tooth Extractions

- Palliative treatment - emergency treatment to relieve pain or infection of dental origin.
- Restoration of decayed or fractured teeth - includes pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings and tooth-color (composite) fillings. *Limitation: If you choose a tooth-colored filling to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.*
- Occlusal Adjustment - reshaping the biting surfaces of one or more teeth. *Limited to twice per Plan Year.*
- Routine oral surgery: including removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology or dysfunction of dental origin. *Limitation: General anesthesia/sedation is covered only when provided in conjunction with covered oral surgery and when billed by the operating dentist.*

Endodontic Services (Root Canals)

- Apicoectomy/periradicular surgery - surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.
- Direct pulp cap - covering exposed pulp with a dressing or cement to protect it and promote healing and repair.

- Pulpotomy - removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.
- Retrograde fillings - sealing the root canal by preparing and filling it from the root end of the tooth.
- Root canal therapy - treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

Periodontal Services (Treatment of Gum and Bone Diseases)

Please Note: Procedures in this category should be reviewed by the Dental Claims Administrator *before* they are performed. See *The Notification Program* section.

- Full Mouth debridement. *Limited to once in a lifetime after 36 months have elapsed since last dental cleaning (prophylaxis).*
- Conservative periodontal procedures (root plaining and scaling) - removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it. *Limited to once every 24 consecutive months for each quadrant of the mouth.*
- Complex periodontal procedures - various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth. *Limited to once every 36 consecutive months for each quadrant of the mouth for natural teeth only.*

  Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.
- Periodontal maintenance therapy - includes various Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling. *Limitation: This procedure may follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, benefits are available up to four times in the first Plan Year and twice per Plan Year thereafter. This procedure replaces the dental cleaning benefit (prophylaxis) described under Diagnostic and Preventive Services above.*

CLASS III Dental Benefits - Major Restorative Services

High Cost Restorations - Cast Restorations

Limitation: Procedures in this category are available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

- Cast restorations for complicated tooth decay or fracture - restoring a tooth with a cast filing (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth-colored composite filling.
- Crowns - restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Limitation: Crowns are a benefit only if the tooth cannot be restored with a routine filling. Crowns which are supported by surgically placed dental implants will be limited to the amount paid for a conventional, natural tooth supported crown. Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition abrasion, erosion, and abfraction are not a benefit.* ***Dental implants are not a benefit.***

- Inlays - restoring a tooth with a cast metallic or porcelain filling. *Limited to the amount paid for a silver (amalgam) filling.*
- Onlays - Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.
- Posts and cores - preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.
- Recementation of cast restorations. *Limited to once every 12 consecutive months after 6 months have elapsed since initial placement.*

Prosthetics (Dentures and Bridges)

Limitation: Procedures in this category are available once every 5 consecutive years.

- Bridges - Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs. *Limitation: Bridges that are supported by dental implants will be limited to the amount paid for a bridge supported by natural teeth.* ***Dental implants are not a benefit.***
- Dentures (Complete and Partial) - Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered. *Limitation: Dentures that are supported by surgically placed dental implants will be limited to the amount paid for a conventional, natural-teeth-supported prosthesis.* ***Dental implants are not a benefit.***
- Denture adjustments - *Limited to two per denture per Plan Year after 6 months have elapsed since initial placement.*
- Tissue conditioning - *Limited to two per denture every 36 consecutive months.*

CLASS IV Dental Benefits - Orthodontics (Services to Straighten Teeth)

Orthodontics is treatment that moves teeth by means of appliances that correct a handicapping malocclusion of the mouth.

- Diagnostic procedures: includes cephalometric x-rays and diagnostic cast.
- Appliance therapy (braces): includes related periodic oral exams and adjustments.

When an orthodontic treatment plan is established, the Dental Claims Administrator will calculate an initial payment at the time the banding takes place. Payment for treatment in progress extends only to the months of treatment received while covered under the Plan. The Dental Claims Administrator will determine the months eligible for dental benefits. The balance of the allowed fee will then be divided into payments over the course of treatment, providing dental benefits still exist.

If the Covered Person provides pays for the full course of treatment in advance, then the Covered Person can submit proof of payment to the Dental Claims Administrator, and the Dental Claims Administrator will manually price and pay the full amount of benefits at that time.

Dental Limitations and Exclusions

No benefits will be payable for the following dental expenses:

- **Administrative costs:** include completing claim forms or reports or for providing dental records.
- **Anesthesia or analgesia:** includes charges for local anesthesia or nitrous oxide (relative analgesia) when billed separately from dental procedure performed.
- **Broken appointments:** includes charges for broken or missed dental appointments.
- **Close relative:** includes charges for services or supplies provided by a dentist who is a Close Relative.
- **Complete occlusal adjustment**: includes charges for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth.
- **Complications of a non-covered procedure**.
- **Congenital deformities:** includes charges for services or supplies used to correct congenital deformities, such as a cleft palate.
- **Controlled release devices:** includes charges for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.
- **Cosmetic dentistry:** includes charges for services or supplies primarily used for improving the appearance of teeth, rather than restoring or improving dental form or function. Some examples include: laminate and veneers, teeth whitening or personalization or characterization of prosthetics.
- **Desensitizing medicament or resin:** includes charges for application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.
- **Drugs:** Includes charges for prescription, non-prescription drugs or medicines (see the *Prescription Drug Benefit* section of this SPD).
- **Experimental or Investigative:** includes charges for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.
- **Government program:** includes charges for dental services or supplies that Covered Persons are entitled to claim from any governmental program (except Medicaid) even if the Covered Person waived or failed to claim rights to such services, benefits or damages.
- **Guided tissue regeneration:** includes charges for services or supplies to encourage regeneration of lost periodontal structures.
- **Incomplete services:** includes charges for dental services that have not been completed.
- **Indirect pulp caps.**
- **Infection control:** includes any separate charges for "infection control," which includes the cost for services and supplies associated with sterilization procedures.
- **Implants:** including the surgical insertion or removal of implants.
- **Lost or stolen appliances or devices:** includes charges for any services or supplies required to replace lost or stolen dental appliances or prosthetic devices.
- **Medical services or supplies:** You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

Dental Limitations and Exclusions

- **Medical or dental department maintained by an employer:** includes dental services rendered through a medical or dental department, clinic or similar facility provided or maintained by the Covered Person's employer.
- **Myofunction therapy:** includes charges for myofunction therapy (correction of harmful habits such as thumbsucking).
- **Non-Dentist provider:** includes treatment provided by an individual who is not a licensed dentist or licensed Physician; however, scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of and billed for by a dentist.
- **Not dentally necessary:** includes dental services or supplies that are not necessary according to accepted standards of dental practice.
- **Not legally obligated to pay:** includes charges for dental services or supplies that a Covered Person is not legally obligated to pay for and for which a Covered Person would not be charged in the absence coverage under the Plan.
- **Occupational:** includes charges for any dental services or supplies that may be or could have been compensated under workers' compensation laws, including any services or supplies applied toward the satisfaction of any Deductible under the Employer's workers' compensation coverage.
- **Oral hygiene program:** includes charges for oral hygiene, dietary instruction or plaque control programs.
- **Periodontal appliances:** includes charges for services or supplies related to dental appliances, including night guards for the treatment of gum and bone disease or to limit tooth grinding or jaw clenching.
- **Periodontal splinting:** includes charges for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.
- **Repair, replacement or duplication:** includes charges for repair, replacement or duplication of any orthodontic appliance.
- **Services before coverage:** includes charges for any dental services rendered, supplies ordered or treatment plan otherwise commenced before a Covered Person's coverage under the Plan became effective.
- **Specialized services:** includes charges for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.
- **Splinting:** includes crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are otherwise cosmetic.
- **Temporary or interim procedures:** includes charges for provisional crowns, bridges or dentures.
- **Termination:** includes charges for dental services or supplies received after the date a previously-Covered Person's coverage under the Plan terminates, except as specifically noted above.
- **TMJ:** includes non-surgical treatment, procedures or appliances related to the treatment of TMJ.

Dental Limitations and Exclusions

- **Unerupted teeth:** includes charges for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

Dental Notification Program

This section explains the notification program you or your dentist should follow before you receive certain benefits available under the dental benefit portion of the Plan.

This program is the checks and balances of your dental coverage. It helps:

- Determine that services are dentally necessary and dentally appropriate; and
- Confirm the benefits available under the dental benefit portion of the Plan.

The Approval
The purpose of the notification program is to help control the cost of your benefits—not to keep you from receiving dentally necessary and dentally appropriate treatment.

You should notify the Dental Claims Administrator before you undergo any of the following treatments:

- Periodontal Treatment for Gum and Bone Disease
- High Cost Restorations
- Bridges and Dentures

You should also notify the Dental Claims Administrator before you receive treatment from any benefit category that will exceed $200.

The Dental Claims Administrator's review is based on the treatment plan submitted by your dentist.

The Treatment Plan
A treatment plan describes the treatment your dentist has recommended for you and helps the Dental Claims Administrator determine if the procedure is a dental benefit provided by the Plan as well as dentally necessary and dentally appropriate.

When to Submit a Treatment Plan
You will need to file a treatment plan only if your dentist is nonparticipating — Delta Dental Dentists agree to file for you.

A complete treatment plan includes the plan of treatment and x-rays. Please send the x-rays within 15 working days of receipt of the proposed treatment plan.

Where to Send a Treatment Plan
Submit the proposed treatment plan, along with x-rays and supporting information to:

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

The Treatment Plan Review
Once the Dental Claims Administrator receives the treatment plan and proper documentation, the Dental Claims Administrator will let you and your dentist know if the treatment plan is approved within 15 working days. The Dental Claims Administrator will take one of the following three actions when they receive your treatment plan:

- *Accept* it as submitted.
- *Recommend an alternative benefit.*
- *Deny the treatment plan* because:
  - The procedure is not a benefit of under the dental benefit portion of the Plan; or
  - The procedure is not dentally necessary and dentally appropriate.

Please note: Although the Dental Claims Administrator may approve a treatment plan, neither the Dental Claims Administrator nor the Plan are necessarily liable for the actual treatment you receive from your dentist.

Vision Care Benefits

Vision Care Benefits

Schedule of Vision Care Benefits		
	Network Provider	**Non-Network Provider**
Eye Examination, One per Plan Year*	Covered in Full	Covered up to $50
Eyeglass Frames. Lenses and Lens Options	Covered up to $150 Per Plan Year 20% discount off balance over $150	Covered up to $150 Per Plan Year
Contact Lenses (materials only)		
Conventional	Covered up to $150 Per Plan Year 15% discount off balance over $150	Covered up to $150 Per Plan Year
Disposable	Covered up to $150 Per Plan Year	Covered up to $150 Per Plan Year
Medically Necessary	Covered in Full	Covered up to $210 Per Plan Year
Limitations	One set of frames and lenses **OR** one regimen of contacts (but not both) covered in a 12 month period.	
The following benefit is administered by Auxiant:		
Prescription Safety Glasses (for the Employee only)	Covered up to $150 Per Plan Year	Covered up to $150 Per Plan Year

Additional Eye-Med Discounts - Network Providers Only	
Additional Pairs Benefit	40% discount off complete pair eyeglass purchase and 15% discount off conventional contact lenses
Laser Vision Correction Lasik or PRK from U.S. Laser Network Visit www.eyemedlasik.com or call 1-877-5LASER6	15% discount off the retail price or 5% discount off the promotional price
Hearing Care from Amplifon Hearing Network - Call 1-844-526-5432	40% off hearing exams and a low price guarantee on discounted hearing aids

Vision Care Benefits

Vision Care Benefits under the Plan apply only when vision care charges are incurred by a Covered Person and when the charges are for vision-related services that are recommended and approved by a Physician or Optometrist or Optician. Vision Care Benefits shall be payable for vision care services and supplies as outlined in the *Schedule of Vision Care Benefits*.

The EyeMed Network
EyeMed's network of providers includes private practitioners, as well as the nation's premier retailers, LensCrafters®, Sears Optical, Target Optical, JCPenney Optical and most Pearle Vision locations. To locate EyeMed Vision Care providers near you, visit www.eyemed.com and choose the Insight Network. You may also call EyeMed's Customer Care Center at 1-866-800-5457. EyeMed's Customer Care Center can be reached Monday through Saturday 7:30 am to 11:00 pm EST and Sunday 11:00 am to 8:00 EST.

Using In-Network Providers
When making an appointment with the provider of your choice, identify yourself as an EyeMed member and provide your name and the name of your organization or plan number, located on the front of your ID card. Confirm the provider is an in-network provider for the Network. While your ID card is not necessary to receive services, it is helpful to present your ID card to identify your membership in the Plan.

When you receive services at a participating EyeMed Network Provider, the provider will file your claim. You will have to pay the cost of any services or eyewear that exceeds any allowances, and any applicable co-payments. You will also owe state tax, if applicable, and the cost of non-covered expenses (for example, vision perception training).

Using Out-of-Network Providers
If you receive services from an out-of-network provider, you will pay for the full cost at the point of service. You will be reimbursed up to the maximums as outlined in the *Schedule of Vision Care Benefits*. To receive your out-of-network reimbursement, complete and sign an out-of-network claim form, attach your itemized receipts and send to First American Administrators, Inc., ("FAA"), a wholly-owned subsidiary of EyeMed Vision Care:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-800-5457.

Limitations on EyeMed Discounts
The in-network discounts shown in the *Schedule of Vision Care Benefits* may not be combined with any other discounts or promotional offers. Discounts do not apply to EyeMed provider's professional services, disposable contact lenses or certain brand name vision materials in which the manufacturer imposes a no-discount practice or policy.

Discounts on services may not be available at all participating providers. Prior to your appointment, please confirm with your provider whether discounts are offered.

Vision Care Benefits

Medically Necessary Contact Lenses
The Plan provides coverage for medically necessary contact lenses when one of the following conditions exists:

- Anisometropia of 3D in meridian powers;
- High Ametropia exceeding –10D or +10D in meridian powers;
- Keratoconus where the member's vision is not correctable to 20/30 in either or both eyes using standard spectacle lenses; or
- Vision Improvement for members whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

The benefit may not be expanded for other eye conditions even if you or your providers deem contact lenses necessary for other eye conditions or visual improvement.

International Travel Assistance
No matter where work or play takes you, EyeMed is ready to help when a vision emergency sneaks up while traveling abroad. As an EyeMed member, you have access to international support and resources in 20 countries. From quick fix, temporary glasses to getting you in contact with a trusted provider, we're here to get your trip back in focus. For additional information, call 1-513-765-2870.

Online Contact Lenses with ContactsDirect.com
You can now apply your in-network contact lens benefit at www.contactsdirect.com. Simply complete the online transaction form and the contacts will be delivered directly to your home.

Online Eyewear with Glasses.com
To make sure you get easy, convenient access to vision choices that best fit your lifestyle, we've added Glasses.com to our roster of thousands of independent providers and top optical retailers. This is great news for you because EyeMed members can now apply in-network vision benefits from anywhere, anytime. For additional information visit www.glasses.com.

Vision Care Limitations
No benefits will be payable for the following:

- **Before or after coverage:** Includes charges for vision services or supplies incurred before a Covered Person was covered under the vision care benefit portion of the Plan or after coverage terminates.

- **Frequency:** includes charges for vision examinations or materials received more frequently than the vision care benefit portion of the Plan covers.

- **Medical plan:** includes charges that are covered under a medical plan that reimburses a greater amount for vision care expenses than the Plan.

- **Medical and surgical treatment:** includes charges for services, treatment or supplies related to medical or surgical treatment of the eyes or supporting structures.

- **No prescription:** includes charges for lenses obtained without a prescription.

Vision Care Benefits

- **Replacement:** includes charges for lenses, frames or contact lenses that are lost or broken, except at the normal intervals (i.e., Plan Year) when benefits are available.

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- **Special procedures:** includes charges for special procedures such as orthoptics, vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.

- **Safety glasses:** includes charges for safety glasses for a Covered Person other than the Employee covered under the Plan.

- **Sunglasses:** includes charges for sunglasses, including prescription type.

- **Bifocal substitute:** charges for two pairs of glasses in lieu of bifocals**.**

- **Workers' compensation:** includes charges for services that are or would be compensable under any workers' compensation law or similar legislation.

Employee Assistance Program ("EAP") Benefits

Employee Assistance Program Benefits

Schedule of EAP Benefits
Benefits Included
• Five assessment and/or counseling sessions per family member, per EAP benefit determination period • One half-hour legal consultation (by referral) per EAP benefit determination period (available in Cedar Rapids metro area only) • One hour financial consultation (by referral) per EAP benefit determination period (available in Cedar Rapids metro area only)
Please Note: The EAP benefit determination period does not follow the Plan Year (i.e., calendar year determination period). The EAP benefit determination period begins on June 1 and ends on May 31.

The Employee Assistance Program ("EAP") benefit is comprised of a confidential assessment, counseling, and referral service, and is available to Participants and covered dependents for assistance with problems that affect their personal lives, such as relationships, family, work, emotional health, mental health, and substance abuse concerns. The Board of Trustees has contracted with an EAP provider (Mercy Family Counsel & Employee Assistance Program ("Mercy")), which is an organization of experienced, licensed mental health counselors and social workers to provide confidential, professional assistance to deal with personal problems that may be affecting life at home and at work.

The EAP benefits may include, but are not limited to, treatment of the following:

- Anxiety
- Anger
- Communication skills
- Depression
- Divorce, blended families and co-parenting
- Emotional/mental health concerns
- Grief/loss
- Resolving conflict(s)
- Stress
- Trauma/abuse
- Work/career concerns
- Alcohol/drug abuse
- Financial and legal counseling (available by referral in the Cedar Rapids metro area)

If services are required beyond the assessment and counseling sessions, Mercy will assist you in finding a network provider to maximize your Plan benefits.

Participants and covered dependents may seek to utilize the EAP benefits voluntarily or by mandate (e.g., in the event of a positive alcohol or drug screening) by contacting Mercy directly by telephone: 319-398-6694 (local) or 800-383-6694 (toll-free). Appointments are offered at eight locations. More information is available at www.mercycare.org/EAP.

Short Term Disability Benefits

Short Term Disability Benefits

Schedule of Short Term Disability Benefits	
Short Term Disability Benefit	50% of Employee's contracted hourly rate multiplied by 40 hours, limited to a maximum of 50% of an I.B.E.W. Local 405 Journeyman's wage (based on a 40 hour work week).
Waiting Period (Not Included in the Maximum Period of Payment)	
Disability due to Sickness	14 days Payment to begin on the 15th day of Total Disability
Disability due to Injury	14 days Payment to begin on the 15th day of Total Disability
Maximum Period of Payment	26 weeks

Note: All Bargaining-Unit Employees are eligible for Short Term Disability Benefits. Non-Bargaining Unit Employees may be eligible for Short Term Disability Benefits if these benefits have been elected by their Employer.

This benefit applies when a Participant has a Total Disability that meets all of the following tests:

1. Total Disability starts while the Participant is covered for this benefit. Participant is covered for this benefit as outlined in the *Eligibility and Participation* section of this SPD, including during periods of self-payment of contributions.

2. Total Disability is being continuously treated by a Physician (a chiropractor is not considered a Physician for the purpose of disability benefits).

3. Total Disability is due to an Injury or Sickness that, in either case, is non-occupational -- that is, did not arise from work for wage or profit.

4. Total Disability (Totally Disabled) means your inability, due to Injury or Sickness, to perform substantially all of the material duties of your regular job, including regular attendance on a full-time basis.

Short Term Disability Benefits

The Plan shall reserve the option of requesting periodic physical examinations from either the Participant's current Physician or a Physician of the Trustees' choice. Failure to provide requested Physicians' statements certifying continued Total Disability will result in termination of Short Term Disability benefits. Participants are responsible for providing the following information in a clear and understandable format:

- History of Total Disability (first appearance of symptoms or description of Accidental Injury);
- Diagnosis;
- Dates of treatment;
- Nature of treatment;
- Progress;
- Prognosis;
- Suitability for rehabilitation; and
- Physician's signature and tax I.D. number.

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

Benefit Payment
Benefits will be paid for a Total Disability in an amount not to exceed the limits set forth in the *Schedule of Short Term Disability Benefits*.

Benefits for a Period of Total Disability will end at the earlier of the date the Employee is no longer Totally Disabled, or the date the Employee reaches the Maximum Period of Payment as shown in the Schedule of Benefits, regardless of whether the Employee's active employment terminates during the Period of Total Disability.

Period of Total Disability
Period of Total Disability is the period of time that an Employee is Totally Disabled. Subsequent Periods of Total Disability due to the same or related causes must be separated by return to Active Work for at least 250 hours of work in 3 consecutive calendar months, or 500 hours of work in 6 consecutive calendar months. Subsequent Periods of Total Disability due to different causes must be separated by return to Active Work for at least one day.

Short Term Disability Limitations and Exclusions
No short term disability benefits are payable:

- Until you have seen and been certified as Totally Disabled by a Physician;

- For any period during which you are not under the regular care of a Physician;

- For any days for which you receive holiday or vacation pay during a Period of Total Disability;

- For any period during which you are Totally Disabled as a result of being engaged in an activity primarily for wage, profit or gain, or that could entitle you to benefits under a workers' compensation law or similar legislation;

- For any period during which you are Totally Disabled as a result of engaging in an illegal occupation; committing or attempting to commit an illegal act; participating in a civil insurrection or riot;

performing your duty as a member of the armed forces of any state or country; or war or act of war which is declared or undeclared.

- For any period during which you are performing work for compensation or profit.
- For any period during which you are Totally Disabled as a result of being under the influence of intoxicants or a controlled substance not administered under the advice of a physician.
- For any period during which you are incarcerated.

Life Insurance Benefits

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Accidental Death and Dismemberment Insurance (AD&D) Benefits

Schedule of Life and AD&D Benefits

Schedule of Life and AD&D Benefits	
Life Insurance Benefit:	Principal Sum: $10,000
Accidental Death and Dismemberment Benefits	Principal Sum: $10,000 Life .....Principal Sum Both hands.....Principal Sum Both feet.....Principal Sum Both eyes.....Principal Sum One hand and one foot .....Principal Sum One hand and one eye .....Principal Sum One hand .....One-Half of the .....Principal Sum One foot.....One-Half of the .....Principal Sum One eye.....One-Half of the .....Principal Sum

Life Insurance Benefits

Life insurance benefits are provided under a policy or group insurance issued to the Trustees. This section summarizes the main provisions of the master policy and individual certificates issued by such insurance company. In all cases, the master policy or certificate of insurance will govern life insurance benefit payments.

If a Participant dies from any cause, a life insurance benefit is payable in the amount specified in the *Schedule of Life and AD&D Benefits*. Acceptable proof of death, as determined by the life insurance carrier, must be provided to the Administrative Manager in order for benefits to be paid.

Beneficiary Designation
A Participant must file a written designation of beneficiary with the Administrative Manager, using a properly completed Designation of Beneficiary form, provided by the Administrative Manager. The Participant may change his or her beneficiary designation by filing a new, properly completed form with the Administrative Manager. If the Participant is married and wishes to designate a beneficiary other than the Participant's Spouse, the Participant's Spouse must provide written consent to such designation of beneficiary, unless the Participant's Spouse previously expressly permitted subsequent designations of beneficiary without further consent. You may change your beneficiary designation at any time, but your designation must be on file with the Administrative Manager prior to your death in order to be valid.

In the event a Participant designated his or her former spouse as his or her beneficiary and such marriage was legally terminated by divorce, any prior designation of beneficiary naming such former spouse as beneficiary shall be deemed to be null and void. If the Participant wishes to again name his or her former spouse as beneficiary, the Participant must complete a new Designation of Beneficiary form listing the former spouse as beneficiary following the divorce and file such form with the Administrative Manager.

If more than one beneficiary is named, but the Participant did not designate their order of rights, the beneficiaries will share equally. The share of a beneficiary who dies before the Participant will be passed to any surviving beneficiaries in the order designated. If the Participant does not designate a beneficiary or if the Participant's beneficiary does not survive the Participant, or if the Designation of Beneficiary form is otherwise invalid, the Participant's life insurance benefit will be paid to the Participant's surviving Spouse or, if none, to the Participant's surviving biological or legally adopted child or children, in equal shares or, if none, to the Participant's surviving parents, in equal shares, or if none, to the Participant's surviving siblings, in equal shares, or if none, to the Participant's estate.
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How Life Insurance Benefits are Paid
Life insurance benefit payments shall be payable in a lump sum as soon as administratively feasible after the required documentation is submitted to the Administrative Manager. If two or more beneficiaries are entitled to the Participant's life insurance benefit, each beneficiary will share the life insurance benefit equally, unless specified differently on the Participant's Designation of Beneficiary form on file with the Administrative Manager.

Continuation of Coverage during Total Disability ("Waiver of Premium")
Life insurance coverage will continue without further payment of premiums while a Participant is Totally Disabled if the following conditions are met:

- The Participant became Totally Disabled while covered by the Plan and before reaching age 60;
- The Participant has been Totally Disabled for at least 9 months;
- The Participant or his/her representative notifies the Administrative Manager of the Total Disability within one year from the date the Total Disability started; and

- The Participant provides proof to the Administrative Manager of his/her continuous Total Disability. The first proof must be provided between the 8th and 9th month after the date the Total Disability started. Continuing proof of Total Disability must be given as required by the insurance carrier.

For purposes of this provision, "Total Disability" or "Totally Disabled" means that as a result of sickness or injury, the Participant is unable to perform each of the material duties of any gainful occupation for which he/she is reasonably fitted by training, education or experience.

Notice of Claim
The Administrative Manager must receive written notice of a Participant's death whose life insurance benefit coverage was continued due to Total Disability within 12 months of the date of the Participant's death. If written notice is not provided to the Administrative Manager within such 12-month period, the Plan will not be liable for any payment of life insurance benefit for such Participant.

Termination of Continued Coverage During Total Disability

The Participant's Total Disability will be considered terminated and continued coverage will cease effective as of the date any of the following occur:

- The Participant fails to meet the definition of Total Disability;
- The Participant fails to furnish written proof of continued Total Disability, as required; or
- The Participant fails to submit to a physical examination as may be required by the Board of Trustees or insurance company.

Rights after Termination of Disability
If the Participant ceases to be Totally Disabled, the Participant will be eligible for a life insurance benefit only if he or she satisfies the requirements set forth in the *Eligibility and Participation* section of the SPD in effect at that time. If the Participant fails to satisfy such requirements, the Participant will be eligible for an individual policy of insurance under the conversion privilege.

Conversion Privilege
If your life insurance coverage terminates due to your loss of eligibility under the Plan, you may convert your life insurance to an individual policy at your expense. An application for conversion must be filed within 31 days from the date your life insurance coverage is terminated. Please contact the Administrative Manager for details.

AD&D Benefits

Accidental death and dismemberment (AD&D) benefits are provided under a policy of group insurance issued to the Board of Trustees. This section summarizes the general provisions of the master policy and individual certificates of insurance issued by the insurance company. In all cases, the master policy or certificate of insurance will govern benefit payments.

Employees Only
If an Employee who is covered under the Plan loses a limb or an eye, or if he or she dies from a bodily Injury, the Plan will pay AD&D benefits up to the principal sum set forth in the *Schedule of Life and AD&D Benefits*, provided:

- The loss or Injury was caused solely by an accident that occurred while the Employee is covered under the Plan;
- The loss or Injury is directly related to the accident and is independent of all other causes; and
- The loss or Injury occurred within 90 days of the accident.

The AD&D benefit payment will be made directly to the Participant, if living, otherwise to the Participant's beneficiary.

Loss of a hand or foot means complete severance through or above the wrist or ankle joint, respectively. Loss of an eye means the irrecoverable and complete loss of sight thereof.

Claims and Appeal Procedures

Medical Benefits
Prescription Drug Benefits
HRA Benefits
Dental Benefits
Vision Care Benefits
Short Term Disability Benefits
Life Insurance and Accidental Death & Dismemberment Benefits

Filing Medical Claims

Once you receive medical services, Wellmark must receive a claim to determine the amount of your benefits. The claim lets Wellmark 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.

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 Wellmark.com, by calling the Customer Service number on your ID card or from the Administrative Manager.

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 Wellmark Customer Service number on your ID card.

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

    a. Use a separate claim form for each covered family member and each provider.

    b. Attach a copy of an itemized statement prepared by your provider. Wellmark 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 Participant, 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.

4. **Prescription Drugs Claim Form.** For prescription drugs covered under your medical benefits, use a separate prescription drug claim form and include the following information:

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

5. **Sign the Claim Form**

6. **Submit the Claim**

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

7. **Claims for Services Received Outside the United States**

Send the claim to:

BlueCard Worldwide Service Center
P.O. Box 261630
Miami, FL 33126

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

Notice of Medical Benefit Determinations

Wellmark will send an Explanation of Benefits (EOB) following your claim. The EOB is a statement outlining how benefits were applied to a submitted claim. It details amounts that providers charged, network savings, the 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. This time may be extended by up to 15 days if the claim determination is delayed for reasons beyond Wellmark's control. If Wellmark does not send an EOB statement or a notice of extension within the 30-day period, you have the right to begin an appeal. Wellmark will notify you of the circumstances requiring an extension and the date by which Wellmark expects to render a decision.

If an extension is necessary because additional information is required 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, the processing of your claim may utilize coordination of benefits guidelines.

Once your claim is paid, whether payment is sent to you or to your provider, the Plan's obligation to pay benefits for the claim is discharged. However, a claim may be adjusted due to overpayment or underpayment for up to 18 months after first processed. 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 the Plan's payment.

Medical Claim Appeals

Administration of Medical Claims and Appeals Procedures
Wellmark is the claims fiduciary for medical claims determinations and appeals. Their decision on the payment or denial of a claim is final and binding, except for claims that go to external review, as described below.

Authorized Representative
You may authorize another person to represent you and with whom you want Wellmark to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in Wellmark's Authorized Representative Form. This form is available at Wellmark.com or by calling the Wellmark 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.

Right of Internal Appeal
You have the right to one full and fair review in the case of an adverse benefit determination that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim, a rescission of coverage, or an adverse benefit determination concerning a pre-service notification requirement. Pre-service notification requirements are:

- A precertification request.
- A notification of admission or services.
- A prior approval request.

How to Request an Internal Appeal
You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of the adverse benefit determination by submitting a written appeal. Appeal forms are available at Wellmark.com or the Administrative Manager.

- **Medically Urgent Appeal.** To appeal an adverse benefit determination involving a medically urgent situation, you may request an expedited appeal, either orally or in writing. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision.

- **Non-Medically Urgent Appeal.** To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

- **What to Include in Your Internal Appeal.** You must submit all relevant information with your appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

    - Date of your request.

- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Participant identification number.
- Claim number from your EOB, 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 Internal Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232

Review of Internal Appeal
Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you prior to Wellmark issuing a final adverse benefit determination and you will have the opportunity to respond to that information or to provide information.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, Wellmark will consult an appropriate medical expert who was not previously involved in the original decision and who has no conflict of interest in making the decision. If Wellmark denies your appeal, in whole or in part, you may request, in writing, the identity of the medical expert Wellmark consulted.

Decision on Internal Appeal
The decision on appeal is the final internal determination. Once a decision on internal appeal is reached, your right to internal appeal is exhausted.

- **Medically Urgent Appeal.** For a medically urgent appeal, you will be notified (by telephone, e-mail, fax or another prompt method) of the decision as soon as possible, based on the medical situation, but no later than 72 hours after your expedited appeal request is received. If the decision is adverse, a written notification will be sent.

- **All Other Appeals.** For all other appeals, you will be notified in writing of the decision. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days.

External Review
You have the right to request an external review of a final adverse determination involving a covered service when the determination involved:

- Medical necessity.

- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- Concurrent review or admission to a facility.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under the Plan.

The external review will be conducted by independent health care professionals who have no association with Wellmark and who have no conflict of interest with respect to the benefit determination.

External Review Process

- **Exhaustion of Internal Appeal Process.** Before you can request a non-expedited external review or take legal action, you must first exhaust the internal appeal process described earlier in this section. If you do not receive a notice of a decision regarding the adverse benefit determination within the time periods described above, you may assume that your appeal has been denied on review, in which case, you are considered to have exhausted the internal appeal process.

- **Expedited External Review.** You do not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if you have a medical condition for which the time frame for completing an internal appeal or for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

You may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, concurrent review, or service for which you received emergency services, and you have not been discharged from a facility.

If the adverse benefit determination is that the service or treatment is experimental or investigational and your treating physician has certified in writing that delaying the service or treatment would render it significantly less effective, you may also have the right to request an expedited external review.

You or your authorized representative may submit an oral or written expedited external review request to Wellmark.

If Wellmark determines the request is eligible for an expedited external review, Wellmark will immediately assign an independent review organization ("IRO") to conduct the review and a decision will be made expeditiously, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

- **Non-Expedited External Review.** You or your authorized representative may request a non-expedited external review to be conducted by an IRO by completing an External Review Request Form and submitting the form as described in this section. You may obtain this request form by calling the Wellmark Customer Service number on your ID card or by visiting at Wellmark.com.

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on your request for external review.

Medical Claim Appeals

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

Wellmark Blue Cross and Blue Shield Special Inquiries
P.O. Box 9232, Station 5W189
Des Moines, IA 50306-9232
Fax: 515-376-9073

Upon receipt of a non-expedited external review request, Wellmark will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, Wellmark will assign an IRO to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date Wellmark receives your request for an external review.

Legal Action
You must follow and exhaust the Plan's appeal procedures described in this section completely before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency. You may, at your own expense, have legal representation at any stage of the review process. The Trustees, or their designated representative, have sole discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. In the event you submit a claim for review and the claim is again denied, in whole or in part, any legal action must begin within two years after the end of the calendar year in which the Plan provides an adverse appeal determination.

Prescription Drug Claim and Appeal Procedures

Administration of Prescription Drug Claims and Appeals Procedures
Express Scripts is the claims fiduciary for prescription drug claims determinations and appeals. Its decision on the payment or denial of a claim is final and binding, except for claims that go to external review, as described below.

How to Receive Prescription Drug Benefits
Retail Pharmacy. Your Plan ID card also serves as your prescription drug card. You present the card to a retail pharmacy to have your prescriptions filled. If, for some reason, you do not have your card with you when you fill a prescription, you can pay for the prescription drug yourself and file a paper claim for reimbursement afterwards. Claim forms for this purpose are available from Express Scripts (call the Member Services number on your ID card) or the Administrative Manager.

Mail Order Pharmacy. If you take maintenance drugs (medication to treat a long-term condition, such as high blood pressure, asthma or diabetes), you can purchase them from Express Scripts. The toll-free number is on your ID card.

Authorized Representative
You may authorize another person to represent you and with whom you want to communicate regarding specific claims or an appeal. Contact Express Scripts to obtain an Authorized Representative Form.

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.

Types of Reviews and Appeals
There are two categories of reviews and appeals:

- **Administrative** reviews and appeals are based on the plan's benefit design or conditions of coverage without additional information required from the prescriber.
- **Clinical** reviews and appeals are based on conditions of coverage and may require additional information from the prescriber.

The type of review or appeal will affect the contact information for your communications about the review or appeal, as shown below.

Right of Internal Appeal
You have the right to one full and fair review in the case of an adverse benefit determination that denies, reduces, or terminates benefits, or fails to provide payment in whole or in part. Adverse benefit determinations include a denied or reduced claim, a rescission of coverage, or an adverse benefit determination concerning a pre-authorization requirement.

How to Request an Internal Appeal
You or your authorized representative, if you have designated one, may appeal an adverse benefit determination within 180 days from the date you are notified of the adverse benefit determination by submitting a written appeal. Appeal forms are available from the Express Scripts or the Administrative Manager.

- **Medically Urgent Appeal.** To appeal an adverse benefit determination involving a medically urgent situation, you may request an expedited appeal, either orally or in writing. Medically urgent generally means a situation in which your health may be in serious jeopardy or, in the opinion of your Physician, you may experience severe pain that cannot be adequately controlled while you wait for a decision.

- **Non-Medically Urgent Appeal.** To appeal an adverse benefit determination that is not medically urgent, you must make your request for a review in writing.

- **What to Include in Your Internal Appeal.** You must submit all relevant information with your appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

  - Date of your request.
  - Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
  - Participant identification number.
  - Date of service in question.
  - The prescription drug for which coverage has been denied, and
  - Any other information which may be relevant to your claim.

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

Where to Send Internal Appeal

Clinical Appeals	Express Scripts PO Box 66588 St. Louis, MO 63166-6588 ATTN: Clinical Appeals Department Phone: (800) 753-2851
Administrative Appeals	Express Scripts PO Box 66587 St. Louis, MO 63166-6587 ATTN: Administrative Appeals Department Phone: (800) 946-3979

Review of Internal Appeal

Your request for an internal appeal will be reviewed only once. The review will take into account all information regarding the adverse benefit determination whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial determination. Any new information or rationale gathered or relied upon during the appeal process will be provided to you prior to Express Scripts issuing a final adverse benefit determination and you will have the opportunity to respond to that information or to provide information.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment,

Express Scripts will consult an appropriate medical expert who was not previously involved in the original decision and who has no conflict of interest in making the decision. If Express Scripts denies your appeal, in whole or in part, you may request, in writing, the identity of the medical expert that was consulted.

Decision on Internal Appeal
The decision on appeal is the final internal determination. Once a decision on internal appeal is reached, your right to internal appeal is exhausted.

- **Medically Urgent Appeal.** For a medically urgent appeal, you will be notified (by telephone, e-mail, fax or another prompt method) of the decision as soon as possible, based on the medical situation, but no later than 72 hours after your expedited appeal request is received. If the decision is adverse, a written notification will be sent.

- **All Other Appeals.** For all other appeals, you will be notified in writing of the decision. Most appeal requests will be determined within 30 days and all appeal requests will be determined within 60 days.

External Review
You have the right to request an external review of a final adverse determination involving a covered service when the determination involved:

- Medical necessity.
- Appropriateness of services or supplies, including health care setting, level of care, or effectiveness of treatment.
- Investigational or experimental services or supplies.
- Concurrent review or admission to a facility.

An adverse determination eligible for external review does not include a denial of coverage for a service or treatment specifically excluded under the Plan.

The external review will be conducted by independent health care professionals who have no association with Express Scripts and who have no conflict of interest with respect to the benefit determination.

External Review Process

- **Exhaustion of Internal Appeal Process.** Before you can request a non-expedited external review or take legal action, you must first exhaust the internal appeal process described earlier in this section. If you do not receive a notice of a decision regarding the adverse benefit determination within the time periods described above, you may assume that your appeal has been denied on review, in which case, you are considered to have exhausted the internal appeal process.

- **Expedited External Review.** You do not need to exhaust the internal appeal process to request an external review of an adverse determination or a final adverse determination if you have a **medical** condition for which the time frame for completing an internal appeal or for completing a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

You may also have the right to request an expedited external review of a final adverse determination that concerns an admission, availability of care, concurrent review, or service for which you received emergency services, and you have not been discharged from a facility.

If the adverse benefit determination is that the service or treatment is experimental or investigational and your treating Physician has certified in writing that delaying the service or treatment would render it significantly less effective, you may also have the right to request an expedited external review.

You or your authorized representative may submit an oral or written expedited external review request to Express Scripts.

If Express Scripts determines the request is eligible for an expedited external review, they will immediately assign an independent review organization ("IRO") to conduct the review and a decision will be made expeditiously, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

- **Non-Expedited External Review.** You or your authorized representative may request a non-expedited external review to be conducted by an IRO by completing an External Review Request Form **and** submitting the form as described in this section. You may obtain this request form by contacting Express Scripts.

You will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on your request for external review.

Requests must be filed in writing at the following address, no later than four months after you receive notice of the final adverse benefit determination:

Clinical Appeals	Express Scripts PO Box 66588 St. Louis, MO 63166-6588 ATTN: Clinical Appeals Department Phone: (800) 753-2851
Administrative Appeals	Express Scripts PO Box 66587 St. Louis, MO 63166-6587 ATTN: Administrative Appeals Department Phone: (800) 946-3979

Upon receipt of a non-expedited external review request, Express Scripts will make a preliminary review of the request to determine whether the request may proceed to external review. Following that review, they will assign an IRO to conduct the external review. You will be advised of the name of the IRO and will then have five business days to provide new information to the IRO. The IRO will make a decision within 45 days of the date Express Scripts receives your request for an external review.

Prescription Drug Claim and Appeal Procedures

Legal Action

You must follow and exhaust the Plan's appeal procedures described in this section completely before you file a lawsuit under ERISA, the federal law governing employee benefits, or initiate proceedings before any administrative agency. You may, at your own expense, have legal representation at any stage of the review process. The Trustees, or their designated representative, have sole discretionary authority to make final determinations regarding any application for benefits, the interpretation of the Plan and any administrative rules adopted by the Trustees. In the event you submit a claim for review and the claim is again denied, in whole or in part, any legal action must begin within two years after the end of the calendar year in which the Plan provides an adverse appeal determination.

HRA Claim and Appeal Procedures

Administration of HRA Claims Procedures.
The Administrative Manager, whose contact information appears in *Your Plan Identification at a Glance*, processes the Plan's HRA benefits. The Administrative Manager also facilitates the appeals for HRA benefits, but the Board of Trustees makes all final decisions on internal appeals for HRA claims.

How to File a Claim for HRA Benefits
HRA claims must be filed with a claim form, which can be obtained from the Administrative Manager.

Please be advised that you may name an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse decision, provided such authorization must be in writing. Please contact the Administrative Manager for information regarding naming an authorized representative.

Initial Decision on Claim
A claim must be resolved, at the initial level, within 30 days of receipt. The Administrative Manager may, however, extend this decision making period for an additional 15 days for reasons beyond the control of the Administrative Manager. This notice shall explain the circumstances that require an extension and the date the Administrative Manager expects to render a decision to the claimant. The notice shall explain the standards on which entitlement to the benefits is allegedly based, the unresolved issues that prevent a decision and the additional information needed to resolve the issues.

If during the review additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing such information, the Administrative Manager will issue a written notice of the decision. The timing requirement for issuance of a decision will be tolled while the Plan waits for you to provide the additional required information.

Content of Denial Notice
If your claim is partially or wholly denied, you will receive a notice:

- Containing information sufficient to identify the claim, plus a statement that diagnosis and treatment codes, as well as their corresponding meanings, are available upon request;
- Stating the specific reason(s) for the denial and a specific reference to the pertinent Plan provision(s) on which the denial is based;
- Describing and explaining any additional material or information required of you in order to make your claim valid;
- Explaining the Plan's appeal procedure and your right to appeal the initial decision;
- Explaining that the initial decision will be a final decision, unless the decision is appealed as described below;
- Detailing your right to bring a civil action under ERISA section 502(a), and to request an external review with an independent review organization ("IRO"), following an adverse benefit determination on an appeal;
- Notifying you that, if a specific rule or guideline was relied upon, a copy of such rule or guidelines is available upon request; and

- Notifying you that, if the determination is based upon a medical necessity or experimental treatment exclusion, a copy of an explanation of the scientific judgment supporting the determination is available upon request.

Appeal Procedure
If you feel that the action taken on your claim is incorrect, you have the right to appeal to the Board of Trustees, for a further review. The following paragraphs describe the procedure for appealing to the Trustees.

After you receive a notice denying a claim for benefit payment which you feel is incorrect, you should notify the Plan in writing of the wish to have the claim reviewed by the Board of Trustees. Such notice of appeal must be filed within 180 days from the date the written notice of denial was mailed.

The request for review should include all information regarding the claim as well as the reason(s) you feel the original decision was incorrect. Copies of any documents relevant to the claim will be provided at no cost, upon request. The review on appeal will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. If the decision requires medical judgment, the Trustees will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

The Board of Trustees or its authorized Committee shall meet quarterly to render a determination on appeals of HRA benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision shall be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan shall notify the claimant of the reasons for the delay prior to any extension. The Plan shall notify the claimant of the decision within five days of the date the decision is made.

External Review of a Denied Claim.
The Plan offers you the right to request an external review of your HRA claim, if the denial involved medical judgment (e.g., the treatment service or supply was not medically necessary or was experimental/investigational in nature). If you want to have the denied claim reviewed, you must send a written request for an external review of the claim denial to the Administrative Manager no later than four months after the date you receive the notice of denial. Any claimant filing a timely request for review may submit additional materials for consideration on review, including a written explanation of and comments on the issues.

Legal Action.
No lawsuit or other action against the Plan or its Trustees may be filed until you exhaust the Plan's appeal procedure. Further, in the event a claim has been reviewed under the Plan's appeal procedure and the claim has been denied, no lawsuit or other action against the Plan or its Trustees may be filed after one year from the date you or your beneficiary has been given written notice of the Trustees' decision on the appeal. If this time limitation is less than that required by law, the limitation will be extended to agree with the minimum period permitted by law.

Dental Claim and Appeal Procedures

Administration of Dental Claims Procedures. The Plan Administrator has delegated the responsibility for evaluating all dental benefit claims and appeals to Delta Dental, as Dental Claims Administrator.

How to File a Claim for Dental Benefits
Participating Delta Dental Dentists will file claims on your behalf.

If you need a claim form or have any questions after reading this section, please call Delta Dental or visit their website www.deltadental.com. If you must file your own claim, send it to the following address:

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

Please be advised that you may name an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse decision, provided such authorization must be in writing. Please contact Delta Dental for information regarding naming an authorized representative.

When to File a Claim for Dental Benefits
After you receive services, you should file a claim only if your dentist has not filed one for you. Claims must be filed within one year after the date services were rendered.

You should file a claim only after the procedure is completely finished. Do not file for payment before a procedure is completed.

Claim Denials
Delta Dental will decide your claim within a reasonable time not longer than 30 days after it is received. This time period may be extended, however, where a claim is incomplete or there are other circumstances beyond Delta Dental's control. In such a case, Delta Dental will provide you with written notice of any required extension in the time for them to respond, including the reasons for such an extension and information on the date on which a decision is expected to be made. If an extension is necessary because a claim is incomplete, the written notice to you will also request that you provide Delta Dental with certain additional information within 45 days. The time period for Delta Dental to respond to your claim can be extended for an additional 15 days from the date on which Delta Dental receives the requested additional information.

Delta Dental may obtain the advice of independent dentists or require such other evidence as it deems necessary to decide your claim.

If Delta Dental denies your claim, in whole or in part, you will be furnished with a written notice setting forth the following information:

- The specific reasons for the denial;
- Reference to the specific provisions of the Plan on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and

- Appropriate information as to the steps to be taken if you wish to appeal the decision of Delta Dental, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appealing Denied Claims

If you disagree with Delta Dental's reasons for not paying all or part of your claim and think that the service should be covered under this Plan, you or your representative can appeal by asking for a full and fair review of the claim. To file for a review, you must submit a request in writing within 180 days of receiving Delta Dental's notice that it is denying your claim. If you do not submit a request for review within this time period, you will lose your right to review and you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative review rights, which is generally a prerequisite to bringing suit.

Your request for a review should state the reasons why you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) all documents, records, and other information relevant to your claim and its review. Delta Dental will review all written comments that you submit with your request.

Upon request, you can review the records of Delta Dental that are relevant to your claim from 8 a.m. to 4:30 p.m., Central Time, Monday through Friday, at Delta Dental's Johnston, Iowa location. Since Delta Dental maintains many of these records in electronic form, please call or write Delta Dental in advance so they can have paper copies of these records available for your review.

Send your request to:

Delta Dental of Iowa
P.O. Box 9000
Johnston, IA 50131-9000

Delta Dental will review your request and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that person's subordinate. Delta Dental may secure the advice of independent dentists or others and require such evidence as it deems necessary to decide your appeal, except that any dental or other expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of any dental or other expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be given a notice of denial on review that provides the following information:

- The specific reason(s) for the denial;
- The specific provisions of the dental benefits portion of the Plan on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information;
- If Delta Dental relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a

copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and

- A statement of your right to bring suit under ERISA § 502(a).

Vision Claim and Appeal Procedures

Administration of Vision Claims Procedures. The Vision Claims Administrator, whose contact information appears in *Your Plan Identification at a Glance*, processes the Plan's vision care benefits, with the exception of benefits for Prescription Safety Glasses, which continue to be processed by the Administrative Manager. The Vision Claims Administrator also facilitates the appeals for vision care benefits (and the Administrative Manager for Prescription Safety Glasses), but the Board of Trustees makes all final decisions on appeals for vision care claims.

How to File a Claim for Vision Benefits (Except Prescription Safety Glasses)
If you receive services from an in-network provider, the provider will file your claim for benefits. If you receive services from an out-of-network provider, you must file a claim for reimbursement at:

FAA/EyeMed Vision Care
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

For your convenience, a FAA/EyeMed out-of-network claim form is available at www.eyemed.com or by calling EyeMed's Customer Care Center at 1-866-800-5457.

How to File a Claim for Prescription Safety Glasses
A Vision Claim Form must be completed and submitted along with the detailed receipt from the provider to the address below. Claims must be filed no later than 12 months after the date services were provided.

Auxiant
Attn: Union Services
P.O. Box 75008
Cedar Rapids, IA 52407
800-475-2232 ext. 1221

Authorized Representative
Please be advised that you may name an authorized representative to act on your behalf in filing a claim, providing requested information or pursuing an appeal of an adverse decision, provided such authorization must be in writing. Please contact the Vision Claims Administrator/Administrative Manager for information regarding naming an authorized representative.

When to File a Claim for Vision Benefits
After you receive services, you should file a claim only if your provider has not filed one for you. Claims must be filed within one year after the date services were rendered.

Initial Decision on Claim
A claim must be resolved, at the initial level, within 30 days of receipt. The Vision Claims Administrator/Administrative Manager may, however, extend this decision making period for an additional 15 days for reasons beyond the control of the Vision Claims Administrator/Administrative Manager. This notice shall explain the circumstances that require an extension and the date the Vision Claims Administrator/Administrative Manager expects to render a decision to the claimant. The notice shall explain the standards on which entitlement to the benefits is allegedly based, the unresolved issues that prevent a decision and the additional information needed to resolve the issues.

If during the review, additional information is required, you will be so notified within the required time period for notice of a decision detailed above. You will have at least 45 days to provide such information. Following the provision of the required information, or the expiration of the time period for providing

such information, the Vision Claims Administrator/Administrative Manager will issue a written notice of the decision. The timing requirement for issuance of a decision will be tolled while the Plan waits for you to provide the additional required information.

Content of Denial Notice
If your claim is partially or wholly denied, you will receive a notice:

- Containing information sufficient to identify the claim, plus a statement that diagnosis and treatment codes, as well as their corresponding meanings, are available upon request;
- Stating the specific reason(s) for the denial and a specific reference to the pertinent Plan provision(s) on which the denial is based;
- Describing and explaining any additional material or information required of you in order to make your claim valid;
- Explaining the Plan's appeal procedure and your right to appeal the initial decision;
- Explaining that the initial decision will be a final decision, unless the decision is appealed as described below;
- Detailing your right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on an appeal;
- Notifying you that, if a specific rule or guideline was relied upon, a copy of such rule or guidelines is available upon request; and
- Notifying you that, if the determination is based upon a medical necessity or experimental treatment exclusion, a copy of an explanation of the scientific judgment supporting the determination is available upon request.

Appeal Procedure
If you feel that the action taken on your claim is incorrect, you have the right to appeal to the Board of Trustees, for a further review. The following paragraphs describe the procedure for appealing to the Trustees.

After you receive a notice denying a claim for benefit payment which you feel is incorrect, you should notify the Vision Claims Administrator/Administrative Manager in writing of the wish to have the claim reviewed by the Board of Trustees. Such notice of appeal must be filed within 180 days from the date the written notice of denial was mailed.

The request for review should include all information regarding the claim as well as the reason(s) you feel the original decision was incorrect. Copies of any documents relevant to the claim will be provided at no cost, upon request. The review on appeal will consider all comments, documents, records and other information you submit, regardless of whether the information was submitted or considered in the initial determination. If the decision requires medical judgment, the Trustees will consult an appropriate health professional who is not the same health professional or subordinate to any health professional who reviewed the initial claim.

Vision Claim and Appeal Procedures

The Board of Trustees or its authorized Committee shall meet quarterly to render a determination on appeals of vision care benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision shall be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan shall notify the claimant of the reasons for the delay prior to any extension. The Plan shall notify the claimant of the decision within five days of the date the decision is made.

Legal Action.
No lawsuit or other action against the Plan or its Trustees may be filed until you exhaust the Plan's appeal procedure. Further, in the event a claim has been reviewed under the Plan's appeal procedure and the claim has been denied, no lawsuit or other action against the Plan or its Trustees may be filed after one year from the date you or your beneficiary has been given written notice of the Trustees' decision on the appeal. If this time limitation is less than that required by law, the limitation will be extended to agree with the minimum period permitted by law.

Short Term Disability Claim and Appeal Procedures

Administration of Short Term Disability Claims Procedures. The Administrative Manager, as identified in *Your Plan Identification at a Glance*, processes the Plan's short term disability benefits. The Administrative Manager also facilitates the appeals for short term disability benefits, but the Board of Trustees makes all final decisions on appeals.

How to File a Claim for Short Term Disability Benefits
Claim forms are available from the Administrative Manager, whose contact information appears in *Your Plan Identification at a Glance*. You must fill out your part of the form completely and have the I.B.E.W. Local 405 Union Office verify your employment status. You should then give the form to your Physician to certify your Total Disability. Completed forms must be filed promptly with the Administrative Manager, preferably no more than 21 days after the period of disability begins. Your continuing disability may have to be re-certified periodically by your Physician.

Initial Claim Determination
A Claim must be resolved, at the initial level, within 45 days of receipt. The Administrative Manager may, however, extend this decision making period for an additional 30 days for reasons beyond the control of the Administrative Manager.

If, after extending the initial time period of 30 days, the Administrative Manager determines that it is still unable, for reasons beyond the control of the Administrative Manager, to make a decision within the extended time period, the Administrative Manager may further extend the decision making time period for a second 30-day period.

Appropriate notice must be provided to the claimant before the end of the initial 45-day decision making period and again before the end of each succeeding 30-day period. This notice shall explain the circumstances that require an extension and the date the Administrative Manager expects to render a decision to the claimant. The notice shall explain the standards on which entitlement to the benefits is allegedly based, the unresolved issues that prevent a decision and the additional information needed to resolve the issues.

The claimant will have 45 days to provide any additional information requested by the Administrative Manager.

Adverse Benefit Determinations
The Administrative Manager shall provide written or electronic notification of any adverse benefit determination. The notice shall state:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Plan provisions on which the determination was based;
- A description of any additional material or information pertaining to the claim that the claimant must provide to the Administrative Manager and an explanation of the significance of such material or information;
- A description of the Plan's claim review procedures and applicable time limits and a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination or review.

- A statement that the claimant is entitled to receive reasonable access to and copies of all documents, records and other information relevant to the claim, upon request and free of charge.

If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, a copy of such rule, guideline, protocol, or criterion will be provided free of charge, upon request.

Appeals
The claimant has 180 days following receipt of an adverse benefit determination notification in which to appeal the decision. A claimant may submit additional written comments, documents, records and other information relating to the claim to the Administrative Manager for review by the Trustees. The claimant may request reasonable access to and copies of all documents, records and other information relevant to the Claim, free of charge.

A document, record, or other information shall be considered relevant to a claim if it:

- Was relied upon in making the benefit determination;

- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

- Demonstrated compliance with the administrative processes and safeguards, which are designed to ensure and verify that benefit determinations are made in accordance with Plan documents and that Plan provisions are applied consistently with respect to all claimants; or

- Constituted a statement of policy or guidance with respect to the Plan concerning the denied benefit.

The review shall take into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be considered by the Board of Trustees.

The Board of Trustees or its authorized Committee shall meet quarterly to render a determination on appeals of short term disability benefits received since the prior meeting, provided any appeal filed within the 30-day period preceding a meeting shall be decided at the next following quarterly meeting. If special circumstances require a delay in the decision, the decision shall be rendered no later than the third quarterly meeting following receipt of the appeal, and the Plan shall notify the claimant of the reasons for the delay prior to any extension. The Plan shall notify the claimant of the decision within five days of the date the decision is made.

Legal Action
No lawsuit or other action against the Plan or its Trustees may be filed until you exhaust the Plan's appeal procedure. Further, in the event a claim has been reviewed under the Plan's appeal procedure and the claim has been denied, no lawsuit or other action against the Plan or its Trustees may be filed after one year from the date you or your beneficiary has been given written notice of the Trustees' decision on the appeal. If this time limitation is less than that required by law, the limitation will be extended to agree with the minimum period permitted by law.

Life and AD&D Claim and Appeal Procedures

Administration of Life & AD&D Claims Procedures. The Insurer, as identified in *Your Plan Identification at a Glance,* is the claims fiduciary for life and AD&D claims determinations and appeals. Its decision on the payment or denial of a claim is final and binding.

How to File a Claim for Life or AD&D Benefits
To obtain a claim form for life insurance benefits or AD&D benefits, contact the Administrative Manager, whose contact information is shown in *Your Plan Identification at a Glance.*

All claims should be reported promptly. The deadline for filing a claim for life insurance benefits or AD&D benefits is 90 days after the date of the loss causing the claim. If, through no fault of your own, you are unable to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than one year after the 90-day deadline.

Initial Benefit Determination

Notification of Adverse Benefit Determination.
The Insurer may make an adverse benefit determination of a claim for benefits. The Insurer will provide written or electronic notification to the claimant of the adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the Insurer. The notice of adverse benefit determination will:

- State the specific reason or reasons for the adverse benefit determination;
- Refer to specific Plan provisions on which the adverse benefit determination is based;
- Describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary; and
- Describe the Plan's review procedures and the time limits applicable to such procedures. The notice shall include a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

An adverse benefit determination includes any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility for Plan coverage.

Extension of Time for Processing a Claim
If the Insurer determines that an extension of time for processing the claim is required, the Insurer will provide written notice of the extension to the claimant before the end of the initial 90 day period. The notice must explain the special circumstances requiring a delay in the decision and set a date, no later than 180 days after the initial receipt of the claim, by which the claimant can expect to receive a decision.

Appeal of Adverse Benefit Determinations
A claimant who receives an adverse benefit determination will be entitled to a full and fair review of that determination. Within 60 days following the receipt of an adverse benefit determination, a claimant must file a written appeal of the adverse benefit determination with the Insurer. The claimant may submit written comments, documents, records, and other information relating to the claim for benefits with the

appeal. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

A document, record or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information:

- Was relied upon in making the adverse benefit determination;
- Was submitted, considered, or generated in the course of making the adverse benefit determination, without regard to whether such document, record, or other information was relied upon in making the adverse benefit determination; or
- Demonstrates compliance with the administrative processes and safeguards required in making the adverse benefit determination.

Review of Denied Claim
The Insurer's review of the claim shall take into consideration all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Insurer's determination on review is binding on all parties.

Notification of Benefit Determination on Review
The Insurer shall provide the claimant with written or electronic notification of a benefit determination on review. The Insurer shall provide the notice within a reasonable period of time, but not later than 60 days after receipt of the claimant's request for review by the Insurer (unless there is a review by a committee). The Insurer may determine that an extension of time for processing the claim is required. If an extension is required, the Insurer shall provide written notice of the extension to the claimant before the end of the initial 60-day period. The notice must indicate the special circumstances requiring an extension of time and the date by which the Insurer expects to render the determination on review. The extension of the determination on review shall not exceed a period of 60 days from the end of the initial period.

The notification of determination on review will:

- State the specific reason or reasons for the adverse benefit determination;
- Refer to the specific Plan provisions on which the adverse benefit determination is based;
- State that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- State the claimant's right to bring an action under section 502(a) of ERISA.

Calculation of Time Periods
The period of time for making a benefit determination begins when a claim is filed in accordance with the reasonable filing procedures of the Plan. The period of time begins without regard to whether all of the information necessary to decide the claim accompanies the filing. Days are measured in calendar days. In the case of a benefit determination on review, if the 60-day period for review is extended due to the claimant's failure to submit information necessary to decide the claim, the total 120-day period for processing the claim is suspended from the date on which notice is sent to the claimant to the date on which a response from the claimant is received by the Insurer.

Life and AD&D Claim and Appeal Procedures

Other Payment Provisions

Assignment of Benefits
Facility of Payment
Right of Recovery and Recoupment
Coordination of Benefits
Integration With Medicare
Effect of Medicaid Coverage
Subrogation and Reimbursement
Worker's Compensation

Other Payment Provisions

Assignment of Benefits
Benefits may not be assigned except by consent of the Board of Trustees other than to providers of medical services and according to the provisions set forth in the Plan's governing documents. Amounts payable at any time may be used to make direct payments to service providers for covered services. Although the Plan may send payments for the claims to the service provider after approving an authorization for direct payment, it will send all claim documentation, such as an explanation of benefits, and any procedures for appealing a claim denial directly to the Participant.

Facility of Payment
Every Participant receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator shall receive a written notice, in a form and manner acceptable to the Plan Administrator, that such Participant is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed. If, however, the Plan Administrator shall find that any person to whom a benefit is payable under the Plan is unable to care for his affairs because of any mental or physical incompetency or because he is a minor, any payment due (unless a prior claim shall have been made by a duly appointed legal representative of his estate) may be paid to the Spouse, a child, a parent, or a sibling, or beneficiary or to any person with whom he or she is residing, or to any other person or institution deemed by the Plan Administrator to have incurred expense for such person otherwise entitled to payment.

In the event a guardian, conservator or other person legally vested with the care of the estate of any Participant receiving or claiming benefits under the Plan shall be appointed by a court of competent jurisdiction, payments shall be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

Rights of Recovery and Recoupment
Whenever payments have been authorized by the Board of Trustees with respect to 1) allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, 2) benefits for which payment was not due and payable under the terms of the Plan or 3) when the Covered Person has not cooperated with the Plan or has done something to compromise the Plan's rights or has refused to reimburse the Plan from any recoveries (collectively known as "erroneous payments"), the Board of Trustees will have the right, exercisable in its sole discretion, to recover such erroneous payments plus related amounts (e.g. interest and costs), from any one or more of the following sources:

- Any service provider, insurance company, or other entity to whom such unauthorized payment or overpayment was made, thus making the Participant personally liable for such amounts; or

- The Participant or dependent to whom or on whose behalf such erroneous payment was made, including by making deductions from benefits payable to them, or on their behalf to third parties, or causing other adjustments of benefits or payments which may be payable in the future; or

- The estate or legal representative of the Participant or dependent to whom or on whose behalf such erroneous payment was made;

The Plan shall be permitted to pursue legal and equitable remedies (e.g., an equitable lien by agreement, constructive trust, offset or setoff) to recover erroneous payments and related amounts. The Plan may recover erroneous payments and related amounts by offsetting amounts payable to or on behalf of the

Other Payment Provisions

Participant or dependent.

The Trustees shall select the interest rate for any erroneous payments.

Coordination of Benefits

This Coordination of Benefits provision applies to medical and dental benefits only. The Coordination of Benefits provision is intended to prevent the payment of benefits that exceed expenses. It applies when the Participant or any eligible dependent who is covered by the Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. The Plan will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan or plans will not exceed 100% of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to the Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

All benefits contained in the Plan are subject to this provision.

Definitions
The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

- Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
    - Hospital indemnity benefits.
    - Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims.
- Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
- Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
- A licensed Health Maintenance Organization ("HMO").
- Any coverage for students that is sponsored by or provided through a school or other educational institution.
- Any coverage under a governmental program and any coverage required or provided by any statute.
- Group automobile insurance.
- Individual automobile insurance coverage on an automobile leased or owned by a Contributing Employer.
- Individual automobile insurance coverage based upon the principles of "No-Fault" and/or Personal Injury Protection coverage.
- Medical payment coverage under any group or individual automobile policy.

Coordination of Benefits

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement that reserves the right to take the benefits or services of other plans into consideration in determining its benefits and to that portion that does not.

The term "allowable expenses" means any necessary item of expense, the charge for which is Usual, Customary, and Reasonable, at least a portion of which is covered under at least one of the plans covering the person for whom Claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

In the case of an HMO or other in-network-only plans, the Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, the Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

Coordination Procedures
Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of allowable expenses incurred during any Plan Year with respect to a Covered Person eligible for:

- Benefits either as an insured person or Participant or as a dependent under any other plan which has no provision similar in effect to this provision, or

- Dependent benefits under the Plan for a Covered Person who is also eligible for benefits:

    - As an insured person or participant under any other plan, or

    - As a dependent covered under another group plan.

- Benefits under the Plan for an Employee who is also eligible for benefits as an insured person or participant under any other plan and has been covered continuously for a longer period of time under such other plan.

Order of Benefit Determination
Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans.

2. The Plan shall be "secondary" in coverage to any no fault automobile insurance policy, regardless of any election made to the contrary by a covered Plan Participant. Any available no-fault insurance shall be the "primary" coverage for any health care bills incurred as a result of any auto accident.

3. The plan that covers the claimant as an employee or named insured pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the claimant as a dependent.

4. If the claimant is a dependent child, the plan of the parent whose birthday occurs first in the Plan Year shall pay first. However, if the child's parents are divorced, then:

a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility; in which case, that parent's plan would pay first.

b. The plan of a stepparent with whom the child lives pays second (if applicable).

c. The plan of the parent without custody pays third.

5. The plan covering the individual as an active employee or a dependent of an active employee shall be primary.

6. The benefits of a plan that covers a person as an employee, who is neither laid off nor retired, are determined before those of a plan that covers such person as a laid off or retired employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

7. If the order set out above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will pay first.

Right to Receive and Release Necessary Information
For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the Board of Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person that the Board of Trustees deems to be necessary for such purposes. Any person claiming benefits under the Plan shall furnish to the Board of Trustees such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments that should have been made under the Plan in accordance with this provision have been made under any other plan or plans, the Board of Trustees will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it shall determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments, the Board of Trustees will be fully discharged from liability under the Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of the Plan, rather than the amount payable in the absence of this provision.

Medicare/Medicaid

Integration of Benefits with Medicare

If you are eligible for Medicare and receive covered services for which benefits are payable under the Plan, then the Claims Administrator will determine if the Plan is primary or secondary to coverage provided by Medicare Parts A and B, based on your status on the date the covered service is rendered. Primary means that benefits payable under the Plan will be determined and paid without regard to Medicare Parts A and B.

Who Pays First?

1. The Plan will always be primary to Medicare Parts A and B if you:

    a. Are an eligible Employee age 65 or older who has current employment status with a Contributing Employer, or the Spouse age 65 or older of an eligible Employee who has current employment status with a Contributing Employer; or

    b. Are under age 65 and entitled to Medicare due to Social Security disability, and are covered due to a Participant's current employment status; or

    c. Are entitled to benefits under Medicare because of end stage renal disease ("ESRD") (kidney disease) during the "coordination period" prescribed by Medicare regulations (currently the first 30 months).

2. The Plan will be secondary to Medicare Parts A and B if you:

    a. Have been entitled to benefits under Medicare because of end stage renal disease ("ESRD") (kidney disease) for longer than the "coordination period" prescribed by Medicare regulations (currently the first 30 months).

    b. Are over 65 and do not have current employment status with a Contributing Employer or are not the dependent of a Participant with current employment status with a Contributing Employer (e.g., you are a retiree or dependent of a retiree, or a COBRA beneficiary who is not in the ESRD coordination period.)

For more information, see Medicare Publication No. 02179, "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can find it at www.medicare.gov/publications.

Should I enroll in Medicare Parts A and B if this Plan pays primary?

Even if you keep working after you turn age 65, you should sign up for Medicare Part A. Part A may still help pay some of the costs not covered by the Plan, and it doesn't cost you anything. Call the Social Security Administration at 1-800-772-1213 to sign up.

However, you may want to wait to sign up for Medicare Part B if you are still working and covered by the Plan. You would have to pay the monthly Medicare Part B premium, and the Medicare Part B benefits may be of limited value to you as long as the Plan is the primary payer of your medical bills. Once you stop working, you can enroll in Part B without paying the higher premium penalty usually associated with late enrollment. For more information, see Medicare Publication No. 11219, "Understanding Medicare Enrollment Periods." You can find it at www.medicare.gov/publications.

Should I enroll in Medicare Parts A and B if this Plan pays secondary?

Yes. If the Plan is secondary, and you do not enroll for coverage under Part A and Part B of Medicare or do not make a claim for Medicare Part A and B benefits, the Claims Administrator will calculate benefits

under the Plan as if you were enrolled in Part A and Part B of Medicare and full claim for Medicare Part A and B benefits had been made.

Effect of Medicaid Coverage

Assignment of Rights
The Plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid
Your receipt or eligibility for benefits under Medicaid will not affect your enrollment as a Participant or beneficiary in the Plan, nor will it affect the determination of your benefits.

Acquisition by States of Rights of Third Parties
If payment has been made by Medicaid and the Plan has a legal obligation to provide benefits for those services, the Claims Administrator will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Medicaid Reimbursement
When a PPO or participating provider submits a claim to a state Medicaid program for a covered service and the Plan reimburses the state Medicaid program for the service, the Plan's total payment for the service will be limited to the amount paid to the state Medicaid program. No additional payments will be made to the provider or to you.

Subrogation and Reimbursement

This subrogation and reimbursement provision applies to all benefits offered by the Plan except life insurance and accidental death and dismemberment insurance.

Definitions
These terms shall have the following meanings in this subrogation and reimbursement provision:

- "Individual" means the Covered Person or representatives, guardians, beneficiaries, fiduciaries, trustees, estate representatives, heirs, executors, administrators of any special needs trusts, and any other agents, persons or entities that may receive a benefit on behalf of the Covered Person.

- "Source" includes, but is not limited to, a responsible party and/or a responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured motorist coverage, underinsured motorist coverage, home owners insurance coverage, injury compensation program and any employer of the Individual under the provisions of a workers' compensation or occupational disease law.

Plan's Rights to Subrogation and Reimbursement

Statement of Rights
The Plan shall be subrogated to all rights of recovery of an Individual to the extent of any amounts which the Plan has paid or may become obligated to pay on account of any claim against a Source in connection with the Injury, Sickness, disease, disability, accident or condition to which the claim relates. The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim by the Plan, to reimbursement from the proceeds of any settlement, judgment or payments from any Source that may result from the exercise of any rights of recovery by the Individual.

Priority Rights
Such subrogation and reimbursement rights shall apply on a priority, first-dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether an Individual is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses and regardless of whether liability is admitted to or contested by any Source. The Individual shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying Injury, Sickness, disease, disability, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Plan, in its sole discretion, has agreed in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses. The Plan specifically disavows any claims that an Individual may make under any federal or state common law defense, including but not limited to, the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment.

Automatic Lien/Constructive Trust
Once the Plan makes or is obligated to make payments on behalf of an Individual on account of the claim, the Plan is granted, and the Individual consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by the Individual from any Source.

Excess Benefits
If at the time of the Injury, Sickness, disease, disability, accident or condition there is available, or potentially available proceeds from any Source, the benefits under this Plan shall apply only as an excess over such proceeds.

Subrogation and Reimbursement

Wrongful Death
In the event that the Individual dies as a result of his or her Injury, Sickness, disease, disability, accident or condition and a wrongful death or survivor claim is asserted against any Source, the Plan's subrogation and reimbursement rights shall still apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as award to the Individual's estate or to surviving Covered Persons, representatives, guardians, beneficiaries, trustees, estate representatives, heirs, executors or administrators of special needs trusts.

Action Required of Individual

Cooperation and Assistance
If requested in writing by the Plan, the Individual shall take such action as may be necessary or appropriate to recover payments made or to be made by the Plan from any Source and shall hold that portion of the total recovery from any Source which is due for payments made or to be made in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery thereof. The Individual shall not do anything to impair, release, discharge or prejudice the rights referred to in this section, and shall not dissipate any amount of recovery to which the Plan claims an equitable lien by agreement. The Individual shall assist and cooperate with representatives designated by the Plan to recover payments made by the Plan and shall do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

Execution of Agreement
The Plan may also require the Individual to execute a Subrogation and Reimbursement Agreement ("Agreement"), in a form provided by and acceptable to the Plan, as a condition to receiving benefits for a claim. If the Agreement is not executed by the Individual(s), at the Plan's request, or if the Agreement is modified in any way without the consent of the Plan, the Plan may suspend all benefit payments. However, in its sole discretion, if the Plan advances claims in the absence of an Agreement, or if the Plan advances claims in error, said payments will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights to reimbursement or subrogation. If the Individual is a minor or incompetent to execute the Agreement, that person's parent, the Individual (in the case of a minor dependent child), the Individual's spouse, or legal representative (in the case of an incompetent or deceased adult) must execute the Agreement upon request of the Plan. An Individual must comply with all terms of the Agreement, including the establishment of a trust for the benefit of the Plan. In this regard, the Individual agrees that out of any Source the identified amount that the Plan has advanced or is obligated to advance in benefits will be immediately deposited into a trust for the Plan's benefit and that the Plan shall have an equitable lien by agreement which shall be enforceable if necessary under legal, equitable and/or injunctive action to ensure that these amounts are preserved and not disbursed. The Plan's subrogation and reimbursement rights shall apply regardless of whether the Individual executes an Agreement.

Plan as Co-Payee
The Individual agrees to include the Plan's name as a co-payee on any and all settlement drafts.

Individual's Minor Status
In the event the Individual is a minor as the term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned. If the minor Individual's parents or court-appointed guardian fails to take such action, the Plan shall have no obligation to advance payment of benefits on behalf of the minor

Individual. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor Individual's parents or court-appointed guardian.

Enforcement.

Methods of Recovery
The Plan has the right to recover amounts representing the Plan's subrogation and reimbursement interests under this section through any appropriate legal or equitable remedy, including, but not limited to, the initiation of a recognized cause of action under ERISA section 502(a)(3) (including injunctive action to ensure the claim amounts that the Plan has advanced are preserved and not disbursed or dissipated) or applicable federal or state law and the imposition of a constructive trust or the filing of a claim for equitable lien by agreement against any recipient of monies recovered from any Source, whether through settlement, judgment or otherwise. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

No Tracing Required
The Plan's equitable lien by agreement imposes a constructive trust upon the assets received as a result of a recovery by the Individual, as opposed to the general assets of the Individual, and enforcement of the equitable lien by agreement does not require that any of these particular assets received or identifiable amounts be traced to a specific account or other destination after they are received by the Individual.

Plan's Right of Offset
Further, in the event an Individual receives monies as the result of an injury, sickness, disease, disability, accident or condition and the Plan is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such injury, sickness, disease, disability, accident or condition, the Plan shall have the right to reduce future payments due to such Individual or the Employee of whom such Individual is a dependent or any other dependent of such Employee by the amount of benefits paid by the Plan. The right of offset shall not, however, limit the rights of the Plan to recover such monies in any other manner described in this section.

Language Interpretation
The Board of Trustees retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

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), the Plan is entitled to reimbursement to the extent of benefits paid under the Plan from your employer, your employer's workers' compensation carrier, or you in the event that your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, the Plan is entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. The Plan will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

The Plan utilizes industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. The Plan reserves the right to seek reimbursement of any such claim or to waive reimbursement of any claim, in its discretion.

Glossary

Glossary

The following definitions apply to the Plan in general. To the extent that a different definition of the same term appears in this SPD, that definition will apply within that section.

ACCIDENTAL INJURY
A condition which is the result of bodily Injury caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences. This incident must be a sufficient departure from the claimant's normal and ordinary lifestyle or routine. The condition must be an instantaneous one, rather than one that continues, progresses or develops.

ACTIVELY AT WORK or ACTIVE WORK
An Employee is considered to be Actively at Work when performing, in the customary manner, all of the regular duties of his or her occupation. An Employee shall be deemed Actively at Work on each day of a regular paid vacation; on a regular non-working day, provided they were Actively at Work on the last preceding regular working day; or as otherwise noted in the *Eligibility and Participation* section of this SPD.

ADMINISTRATIVE MANAGER
The person or firm employed by the Board of Trustees to provide administrative services to the Plan in connection with the operation of the Plan and any other functions, including the collection of contributions, maintenance of eligibility, recordkeeping and carrying out policy decisions made by the Board of Trustees. The Administrative Manager is identified in the *Your Plan Identification at a Glance* section of this SPD.

BOARD OF TRUSTEES or TRUSTEES
The Board of Trustees is comprised of the Trustees appointed pursuant to the Trust Agreement, together with their successors. The Board of Trustees shall be the Plan Administrator of the Plan as that term is used in ERISA.

CLAIM
Any request for a Plan benefit made by a claimant or by a representative of a claimant or by a representative of claimant that complies with the Plan's reasonable procedure for making benefit claims.

CLAIMS ADMINISTRATOR
The person or firm employed by the Board of Trustees to provide benefit claims administration services for each benefit offered by the Plan. There may be a separate claims administrator for each benefit.

CLOSE RELATIVE
The Spouse, parent, brother, sister, child, or in-law of a Covered Person.

COBRA
Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COVERED PERSON
Any Employee or dependent of an Employee meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

DEDUCTIBLE
A specified dollar amount of covered expenses which must be incurred during a Plan Year before any other covered expenses can be considered for payment.

Glossary

EMPLOYEE
An active employee represented by the I.B.E.W. Local 405 and working for an Employer, as defined herein, and with respect to whose employment an Employer is required to make contributions into the Trust Fund on that employee's behalf. An active employee working for an Employer who is required to make contributions into the Trust Fund on that employee's behalf pursuant to a participation agreement or other agreement is also included in this definition. An Employee must receive a W-2 form from the Employer. Other than Employees Actively at Work, the term Employee does not include anyone eligible for Medicare.

EMPLOYER OR CONTRIBUTING EMPLOYER
Any association or individual Employer that has duly executed a collective bargaining agreement with the I.B.E.W. Local 405 and is thereby required to make contributions to this Plan on behalf of its Employees. Any Employer not presently party to such collective bargaining agreement who satisfies the requirements for participation as established by the Trustees, agrees to be bound by the Trust Agreement, enters into a participation agreement with the Trustees and is thereby required to make contributions to this Plan on behalf of its Employees, is also included in this definition. I.B.E.W. Local 405 and Cedar Rapids Electrical Apprenticeship Training and Educational Trust are also considered Employers for purposes of contributions on behalf of its Employees only.

ERISA
The Employee Retirement Income Security Act of 1974, as amended.

FAMILY UNIT
An Employee and his or her eligible dependents who are enrolled in the Plan.

FAMILY AND MEDICAL LEAVE ACT
A federal law, effective August 5, 1993, that applies to employers with fifty (50) or more employees, and applicable state laws of a similar nature.

ILLNESS
A bodily disorder, disease, physical Sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Sickness.

INCURRED
An expense is incurred on the date the service is rendered, except as may otherwise specifically be described in this Plan.

INJURY
The term "Injury" shall mean only accidental bodily Injury caused by an external force, occurring while the Plan is in effect. All injuries to one person from one accident shall be considered an "Injury."

LIFETIME
The term "Lifetime," which is used in connection with benefit maximums and limitations, means the period during which an individual is covered under the Plan, whether or not coverage is continuous. Under no circumstances does "Lifetime" mean the duration of the Covered Person's life.

Glossary

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.

PARTICIPANT
Any Employee meeting the eligibility requirements for coverage as set forth in the *Eligibility and Participation* section of this SPD who is properly enrolled in the Plan.

PLAN ADMINISTRATOR OR PLAN SPONSOR
The Board of Trustees is the Plan Administrator and Plan Sponsor, and is solely responsible for the management of the Plan and has the authority to control and manage the operation and administration of the Plan. The Board of Trustees has the sole authority and discretion to interpret and construe the terms of the Plan and the Trust Agreement or any other provisions, rules, regulations or procedures relating to the operation of the Plan, and to determine any and all questions in relation to the administration, interpretation, or operation of the Plan, including, but not limited to, eligibility under the Plan, the terms and provisions of the Plan, including any alleged vague or ambiguous term or provision, and to determine payment of benefits or claims under the Plan and any and all other matters arising under the Plan. Benefits will be paid only if the Board of Trustees concludes, in its sole and absolute discretion, that the applicant is entitled to them. The Board of Trustees has the final and discretionary authority to determine the Usual, Customary and Reasonable Charges.

The Board of Trustees may employ persons or firms to process claims and perform other Plan-connected services. The Board of Trustees is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and is the named Administrator within the meaning of Section 3(16)(A) of ERISA. To the extent any such duties may be delegated to others, the Board of Trustees retains the right to ultimately decide all appeals, in their sole and absolute discretion. The Board of Trustee's interpretation will be final and binding on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Board of Trustees is challenged in court, it is the intention of the parties that such decision shall be upheld unless it is determined to be arbitrary or capricious. The Board of Trustees has the authority and reserves the right to amend, modify or discontinue all or part of the Plan whenever, in its sole discretion and judgment, conditions so warrant. No amendment of the Plan shall cause any part of the Trust Fund to be used or diverted for purposes other than for the benefit of Participants or their beneficiaries covered by the Plan.

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

PLAN YEAR
A 12-month period commencing on January 1 and ending on December 31 of the same given year.

PHYSICIAN
A legally-licensed medical doctor or surgeon, osteopath, or registered clinical psychologist to the extent that same, within the scope of his or her license, is permitted to perform services provided in this Plan. A Physician shall not include the Covered Person or any Close Relative of the Covered Person.

Glossary

PREGNANCY
The physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

SICKNESS
A person's Illness, disease or Pregnancy (including complications). A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Sickness.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
A Qualified Medical Child Support Order (QMCSO) is a court order that requires an Employee to provide medical coverage for his or her children and meets the requirements of ERISA Section 609(a). The Plan will provide benefits in accordance with the applicable requirements of any QMCSO. The Administrative Manager will furnish a copy of the Plan's QMCSO procedures upon request and free of charge.

SPOUSE
Effective June 26, 2015, a man or woman lawfully married to a covered Participant under any state law (or the law of any U.S. territory or possession or any foreign jurisdiction with legal authority to sanction marriages), including common law marriage, regardless of where the couple lives.

TOTAL DISABILITY (TOTALLY DISABLED)
The complete inability, as a result of Injury or Sickness that did not arise from work for wage or profit, to perform any and every duty of the Employee's occupation or of a similar occupation for which the Employee is reasonably capable, as determined by the Employee's education and training.

TRUST AGREEMENT
The Cedar Rapids Electrical Workers Local 405 Health and Welfare Fund Substituted and Amended Agreement and Declaration of Trust between I.B.E.W. Local 405, the Contributing Employers and the Cedar Rapids/Iowa City, Iowa Chapter, National Electrical Contractors Association, Inc. maintaining the Trust, amended and restated effective May 7, 2013, as amended from time to time.

TRUST FUND
The assets of the Plan held in trust by the Board of Trustees.

USUAL, CUSTOMARY AND REASONABLE CHARGE
This is determined by uniform reference standards as adopted by the Board of Trustees. To be considered a Usual, Customary and Reasonable charge, the charge by a provider for a service must be similar to the charges generally incurred for cases of comparable nature and severity by a dentist or Physician of similar training and experience in the 522, 523, and 524 zip code geographical area. Exception to this would be the dependent children who are domiciled in the zip code zones, but attending an accredited school outside of the noted zip code zones, or Participants and their dependents who are temporarily absent from Eastern Iowa such as on a trip. The application of this provision will be difficult when the Participant is working temporarily outside of these zip code zones under a collective bargaining agreement between an Employer and an affiliate of I.B.E.W. because there is no available work in the above zip code zones. Only under this exception will the Plan pay for covered services based upon the Usual, Customary, and Reasonable Charges used in the area where the service was provided to the Participant and/or dependents; otherwise the Plan will cover charges not to exceed the Usual, Customary and Reasonable Charges used for the above-named zip code areas.

The Plan Administrator has the final and discretionary authority to determine the Usual, Customary and Reasonable Charges.

YOU, YOUR
The Participant and family members eligible for coverage under the Plan.