

## **Notice**

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

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



S U M M A R Y P L A N  
D E S C R I P T I O N

**Casey's General Stores, Inc.  
Employee Healthcare Benefit Plan**



## **Notice To Group Administrator:**

A summary plan description is an important legal document. This summary plan description template has been prepared for your review based on our understanding of your current plan provisions. It may not fit your situation.

You should consult with your attorney regarding the summary plan description's legal and tax implications. Neither Wellmark Blue Cross and Blue Shield of Iowa nor its agents can be responsible for the accuracy or the legal or tax aspects of this summary plan description nor its appropriateness for your situation.

As the plan sponsor, you are responsible for approving the final summary plan description and ensuring it conforms to the terms of the plan. If you wish to change the provisions of this summary plan description, you may ask us to prepare new wording for you and your attorney to review.





An Independent Licensee of the Blue Cross and Blue Shield Association

# **Medical Benefits Plan and Prescription Drugs Benefits Plan**

## **Casey's General Stores, Inc.**

### **NOTICE**

This group health plan is sponsored and funded by your plan sponsor. Your plan sponsor has a financial arrangement with Wellmark under which your plan sponsor is solely responsible for claim payment amounts for covered services provided to you. Wellmark provides administrative services and provider network access only and does not assume any financial risk or obligation for claim payment amounts.

Form Number: Wellmark IA Grp

Group Effective Date: 1/1/2009  
Print Date: 2/5/2009  
Coverage Code: U7L2U5U7M2U6  
Version: 10/08



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# About This Summary Plan Description

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## Important Information

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

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

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

## Charts

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

## Complete Information

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

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

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

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

## Read Thoroughly

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

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

## Plan Description

**Plan Name:** Casey's General Stores, Inc., Employee Healthcare Benefit Plan  
**Plan Sponsor:** Casey's General Stores, Inc.  
**Employer ID Number:** 42-0935283  
**Plan Number:** 501  
**When Plan Year Ends:** December 31  
**Participants of Plan:** See *Coverage Eligibility and Effective Date* later in this summary plan description.  
**Plan Administrator and Agent for Service of Legal Process:** Casey's General Stores, Inc.  
One Convenience Blvd.  
Ankeny, IA 50021  
Phone Number: 515-965-6100  
Service of legal process may be made upon the plan administrator and/or agent.  
**How Plan Costs Are Funded:** Employee pays part of employee and dependent costs.  
**Type of Plan:** Group Health Plan  
**Type of Administration:** Self-Funded  
**Benefits Administered by:** Wellmark Blue Cross and Blue Shield of Iowa  
636 Grand Avenue  
Des Moines, IA 50309-2565

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

## Questions

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

# 1. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire summary plan description, 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.

### Medical Benefits Plan

#### Health Plan Basics

You can receive care from any provider you choose. When you choose a provider who participates in the PPO network, you may reduce your out-of-pocket expenses. To determine if a provider participates with this medical benefits plan, ask your provider, visit our Web site at [www.wellmark.com](http://www.wellmark.com), or [www.bcbs.com](http://www.bcbs.com), refer to your provider directory (a separate document that's available, without charge), or call **800-810-BLUE**.

	Premium Plan	Standard Plan
Benefit Period Deductible	PPO Single: \$300 PPO Family: \$600	PPO Single: \$500 PPO Family: \$1,000
	Non-PPO Single: \$500 Non-PPO Family: \$1,000	Non-PPO Single: \$1,000 Non-PPO Family: \$2,000
Out-of-Pocket Maximum (OPM)	PPO Single: \$2,000 PPO Family: \$4,000	PPO Single: \$3,000 PPO Family: \$6,000
	Non-PPO Single: \$3,000 Non-PPO Family: \$6,000	Non-PPO Single: \$5,000 Non-PPO Family: \$10,000
Coinsurance	PPO 10% Non-PPO 30%	PPO 20% Non-PPO 40%

Non-PPO providers are defined as participating and nonparticipating providers. See *Section 5: Choosing a Provider* for details.

**When You Receive These Covered Services, You Pay:**

	Premium Plan		Standard Plan	
	PPO	Non-PPO	PPO	Non-PPO
<b>Office Visit Services</b>	\$15 copayment	30% coinsurance after deductible	\$20 copayment	40% coinsurance after deductible
<b>Specific Preventive Services*</b> Includes: One routine physical and related services (x-rays, lab work) limited to \$200 per benefit period. Well-child care to age 7 excluded from dollar maximum.	\$15 copayment	30% coinsurance after deductible	\$20 copayment	Not covered
<b>Colonoscopies, Sigmoidoscopies, and Mammograms</b> Services excluded from routine dollar maximum.	\$15 copayment	30% coinsurance after deductible	\$20 copayment	Not covered
<b>Inpatient Hospital and Physician Services</b>	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Outpatient Hospital and Physician Services</b>	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Emergency Room Services, Facility and Physician Charges**</b>	\$75 copayment followed by 10% coinsurance	\$75 copayment followed by 30% coinsurance	\$100 copayment followed by 20% coinsurance	\$100 copayment followed by 40% coinsurance
<b>Ambulance Services</b> Limited to \$5,000 per benefit period.	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Chiropractic Care, including Chiropractic X-Rays</b> Covered up to a \$500 benefit period maximum.	10% coinsurance after deductible	30% coinsurance after deductible		Not covered
<b>Maternity Care</b> Inpatient/Outpatient	10% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
<b>Diagnostic X-Rays and Laboratory Services, Office or Independent Facility</b>	\$15 copayment	30% coinsurance after deductible	\$20 copayment	40% coinsurance after deductible
<b>Allergy Injections, including Serum, Office</b>	\$15 copayment	30% coinsurance after deductible	\$20 copayment	40% coinsurance after deductible
<b>Lifetime Benefits Maximum</b> The maximum amount each covered family member is eligible to receive under this plan for covered services in his/her lifetime.			\$1,000,000	
<b>Lifetime Maximum for Infertility Services</b>		\$2,000		Not covered

Non-PPO providers are defined as participating and nonparticipating providers. See *Section 5: Choosing a Provider* for details.

\*Deductible waived for well-child care.

\*\*Processed at in-network level if true emergency.

## Specialty Rx

Category	You Pay
Copayment	\$85 for specialty drugs.

## Prescription Drug Plan

The amount you pay for your prescriptions depends on the tier to which the drug is assigned and the quantity purchased.

	Premium	Standard
<b>Deductible</b>	\$50 per person \$150 per family*	\$100 per person \$300 per family*
<b>Copayment</b>	\$10 for Tier 1 medications (most generic drugs). \$20 for Tier 2 medications (selected brand name and branded generic drugs). \$45 for Tier 3 medications (other brand name drugs). \$75 for Tier 4 medications. For more information see Tiers, page 50. \$85 for specialty self-administered drugs.	\$15 for Tier 1 medications (most generic drugs). \$25 for Tier 2 medications (selected brand name and branded generic drugs). \$50 for Tier 3 medications (other brand name drugs). \$75 for Tier 4 medications. For more information see <i>Tiers</i> , page 50. \$85 for specialty self-administered drugs.

Visit the Pharmacy section at [www.wellmark.com](http://www.wellmark.com) for more information.

\*Deductible applies to all tiers and must be reached first before the copayment amounts will be applied.

If you purchase a Tier 2, Tier 3, or Tier 4 drug when an A-rated generic drug is available, you are responsible for your deductible and copayment amount plus any difference between the maximum allowable fee for the generic drug and the maximum allowable fee for the brand name drug. You are responsible for this difference even if your provider has specified that you must take the brand name drug.

If the pharmacy's charge is less than the copayment amount, you pay the pharmacy charge.

All drugs must be self-administered according to the instructions given by the practitioner and the pharmacist.

### Drug Quantities

- Mail order prescriptions: 90-day supply for two copayments
- Retail prescriptions: 30-day supply for one copayment
- Generic prescriptions: 30-day supply for one copayment

Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount(s) indicated.

### Covered

- Most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription"
- Drugs dispensed by a pharmacist from a licensed retail pharmacy
- Prescription drugs that are prescribed by a practitioner legally authorized to prescribe
- Insulin and these insulin supplies: needles, syringes, test strips, and lancets
- Oral contraceptives

- Prenatal vitamins
- Smoking cessation drugs are covered, limited to \$400 per individual, per lifetime
- Weight loss drugs, with prior authorization

## Not Covered

- Cosmetic drugs
- Drugs determined to be abused or otherwise misused by you
- Drugs that require a prescription by state law but not federal law
- Growth hormones
- Immunization agents
- Infertility drugs
- Investigational drugs
- Irrigation solutions and supplies
- Nutritional supplements
- Over-the-counter products including nutritional dietary supplements
- Self-help or self-cure programs
- Therapeutic devices or medical appliances

## Payment Details

### Medical Benefits Plan

#### Deductible

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

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

Deductible amounts you pay to PPO or non-PPO providers apply toward meeting both the PPO and the non-PPO deductible amounts. The maximum deductible amount you pay is the non-PPO deductible amount.

Once you meet the deductible, then coinsurance applies.

Deductible amounts are waived for some services.

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

#### Office Visit Copayment.

The office visit copayment:

- applies to covered office services received from PPO practitioners. Laboratory services received from a PPO independent lab are subject to a separate office visit copayment.
- is taken once per practitioner per date of service.

The office visit copayment does not apply to:

- prescription contraceptive devices.
- services received from chiropractors.

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

### **Other Copayment.**

The other copayment:

- applies to outpatient colonoscopies, sigmoidoscopies, and mammograms received from PPO providers.
- is taken once per provider per date of service.

### **Coinsurance**

Coinsurance is an amount you pay for certain covered services. Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance is Calculated*, page 47. Coinsurance amounts apply after you meet the deductible and any applicable copayments.

Coinsurance amounts are waived for some services.

### **Out-of-Pocket Maximum**

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

accumulate toward the out-of-pocket maximum. These amounts include:

- Deductible.
- Coinsurance.

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

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

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

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.
- Emergency room copayments.
- Office visit copayments.
- Other copayments.

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

### **Lifetime Benefits Maximum**

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

Lifetime benefits maximum amounts are accumulated from claim payment amounts under this medical benefits plan and prior medical benefits plans sponsored by your plan sponsor.

## Specialty Rx

### **Copayment**

Copayment is a fixed dollar amount you pay each time a prescription is filled or refilled for a specialty drug.

## Prescription Drug Plan

### **Deductible**

Deductible is the fixed dollar amount you pay for covered drugs in a benefit year before prescription drug plan benefits become available.

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

Once you meet the deductible, then the copayment applies.

The deductible is waived for the following:

- Well-child care immunizations.

### **Copayment**

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled. Copayment amounts apply after you meet the deductible for the benefit year.

## 2. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this summary plan description. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 15. To fully understand which services are covered and which are not, you must become familiar with this entire summary plan description. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

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

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

**Not Covered.** The listed category is generally not covered.

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

**Service/Prescription Maximum.** This column lists maximum benefit amounts that each member is eligible to receive per covered service, prescription, benefit year, or lifetime. Service maximums or prescription maximums that apply per benefit year or per lifetime are reached from claim payment amounts accumulated under this group health plan and any prior group health plans sponsored by your plan sponsor.

**Please note:** Service maximums accumulate for medical and prescription drug benefits separately.

### Medical Benefits Plan

Category	Covered	Not Covered	See Page	Service Maximum
Acupuncture Treatment		⊖	15	
Allergy Testing and Treatment	●		15	
Ambulance Services	●		15	\$5,000 per benefit year.
Anesthesia	●		15	
Blood and Blood Administration	●		15	
Chemical Dependency Treatment	●		15	30 days per benefit year for inpatient treatment. 30 visits per benefit year for outpatient treatment. 60 days per lifetime for inpatient treatment.
Chemotherapy and Radiation Therapy	●		15	

Category	Covered	Not Covered	See Page	Service Maximum
Cosmetic Services		⊗	16	
Counseling Services		⊗	16	
Dental Treatment for Accidental Injury	●		16	
Dialysis	●		16	
Education Services for Diabetes	●		16	10 hours of outpatient diabetes self-management training provided within a 12-month period, plus follow-up training of up to one hour annually.
Emergency Services	●		17	
Fertility and Infertility Services			17	Premium Plan: \$2,000 per lifetime for covered services and supplies related to infertility treatment. Standard Plan: Infertility treatment is not covered.
Genetic Testing	●		18	
Hearing Services (related to an illness or injury)	●		18	
Home Health Services	●		18	
Home/Durable Medical Equipment	●		19	Two pairs of compression garments per benefit year.
Hospice Services	●		19	15 days per lifetime of inpatient hospice respite care. 15 days per lifetime of outpatient hospice respite care. <b>Please note:</b> Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		20	90 days per benefit year of skilled nursing services in a hospital or nursing facility.
Illness or Injury Services	●		20	
Inhalation Therapy	●		20	
Maternity Services	●		20	
Medical and Surgical Supplies	●		21	
Mental Health Services	●		21	30 days per benefit year for inpatient treatment. 30 visits per benefit year for outpatient treatment.
Morbid Obesity Treatment	●		22	\$10,000 per lifetime.
Motor Vehicles		⊗	22	
Musculoskeletal Treatment			22	Premium Plan: Musculoskeletal treatment is covered. Standard Plan: Musculoskeletal treatment is not covered.
Nonmedical Services		⊗	22	
Occupational Therapy	●		22	

Category	Covered	Not Covered	See Page	Service Maximum
Orthotics		⊘	22	
Physical Therapy	●		23	
Physicians and Practitioners			23	
Advanced Registered Nurse Practitioners	●		23	
Audiologists	●		23	
Chiropractors			23	Premium Plan: \$500 per benefit year, including x-ray services. Standard Plan: Chiropractic services are not covered.
Doctors of Osteopathy	●		23	
Licensed Independent Social Workers	●		23	
Medical Doctors	●		23	
Occupational Therapists	●		23	
Optometrists	●		23	
Oral Surgeons	●		23	
Physical Therapists	●		23	
Physician Assistants	●		23	
Podiatrists	●		23	
Psychologists	●		23	
Speech Pathologists	●		23	
Prescription Drugs	●		23	
Preventive Care	●		24	Well-child care until the child reaches age seven. One routine mammogram per benefit year. One routine Pap smear per benefit year. \$200 per benefit year for routine physical examinations and related preventive services. This limit includes: <ul style="list-style-type: none"> <li>■ One routine gynecological examination per benefit year.</li> </ul> This limit does not include: <ul style="list-style-type: none"> <li>■ Colonoscopies.</li> <li>■ Immunizations.</li> <li>■ Mammograms.</li> <li>■ Pap smears.</li> <li>■ Well-child care.</li> </ul>
Prosthetic Appliances	●		25	
Reconstructive Surgery	●		26	
Self Help Programs		⊘	26	
Sleep Apnea Treatment	●		26	
Speech Therapy	●		26	
Surgery	●		26	

Temporomandibular Joint Disorder (TMD)			27	Premium Plan: \$3,000 per lifetime for treatment. Standard Plan: Treatment of temporomandibular joint disorder is not covered.
Transplants	●		27	\$10,000 per operation for costs associated with a member's transportation in an ambulance to a transplant center.
Travel or Lodging Costs	●		27	\$10,000 per transplant for lodging and meals.
Vision Services (related to an illness or injury)	●		27	
Wigs or Hair Pieces	●		28	\$400 per lifetime.
X-ray and Laboratory Services	●		28	

**Prescription Drug Plan**

Prescription Drug Category				Prescription Maximum
	Covered	Not Covered	See Page	
Branded Generic Prescription Drugs	●		28	Retail Prescriptions a 30-day supply. Mail Order Prescriptions a 90-day supply.
Brand Name Prescription Drugs	●		28	Retail Prescriptions a 30-day supply. Mail Order Prescriptions a 90-day supply.
Chemical Dependency Drugs	●		28	
Contraceptives	●		28	
Convenience Packaging		⊙	29	
Cosmetic Drugs		⊙	29	
Drugs that are Lost, Damaged, Stolen, or Used Inappropriately		⊙	29	
Drugs You Abuse		⊙	29	
Generic Prescription Drugs	●		29	a 90-day supply.
Immunization Agents	●		29	
Impotence Drugs	●		29	
Infertility Drugs		⊙	29	
Insulin and Supplies	●		29	
Irrigation Solutions and Supplies		⊙	29	

Prescription Drug Category	Covered	Not Covered	See Page	Prescription Maximum
Nutritional and Dietary Supplements	●		29	
Over-the-Counter Products		⊙	29	
Self-Help Drugs		⊙	30	
Specialty Self-Administered Drugs	●		30	a 30-day supply.
Therapeutic Devices or Medical Appliances		⊙	30	
Tobacco Dependency Drugs	●		30	\$400 per lifetime for tobacco dependency drugs.
Weight Reduction Drugs	●		30	



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## 3. Details - Covered and Not Covered

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All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this summary plan description. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 33. If a service or supply is not specifically listed, do not assume it is covered.

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### Medical Benefits Plan

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#### Acupuncture Treatment

**Not Covered:** Acupuncture and acupressure treatment.

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#### Allergy Testing and Treatment

**Covered.**

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#### Ambulance Services

**Covered:** Professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

**Service Maximum:**

- **\$5,000** per benefit year.

**See Also:**

*Transplants* later in this section.

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#### Anesthesia

**Covered:** Anesthesia and the administration of anesthesia.

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

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#### Blood and Blood Administration

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

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#### Chemical Dependency Treatment

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

**Service Maximum:**

- **30 days** per benefit year for inpatient treatment.
- **30 visits** per benefit year for outpatient treatment.
- **60 days** per lifetime for inpatient treatment.

**Not Covered:**

- Residential facility services.

**See Also:**

*Hospitals and Facilities* later in this section.

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#### Chemotherapy and Radiation Therapy

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

---

## Cosmetic Services

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

**See Also:**

*Reconstructive Surgery* later in this section.

---

## Counseling Services

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

**See Also:**

*Genetic Testing* later in this section.

*Mental Health Services* later in this section.

---

## Dental Services

**Covered:**

- Dental treatment for accidental injuries.
- 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 inpatient or outpatient of a facility only

when you have a medical condition (such as hemophilia) that requires hospitalization.

- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Treatment of abnormal changes in the mouth due to injury or disease.

**Not Covered:**

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

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## 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.

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## Education Services for Diabetes

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

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

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

You are also covered for nutrition education to improve your understanding of your metabolic nutritional condition and provide you with information to manage your

nutritional requirements. Nutrition education is appropriate for, but not limited to:

- Glucose intolerance.
- High blood pressure.
- Lactose intolerance.
- Morbid obesity.

#### **Service Maximum:**

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

---

### **Emergency Services**

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

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a PPO provider, covered services will be reimbursed as though they were received from a PPO provider. However, because we do not have contracts with nonparticipating providers and they may not accept our payment arrangements, you are responsible for any difference between the amount charged and our amount paid for a covered service.

#### **See Also:**

*Nonparticipating providers, page 48.*

---

## **Fertility and Infertility Services**

### **Premium Plan**

#### **Covered:**

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
- Infertility testing and treatment including in vitro fertilization, gamete intrafallopian transfer (GIFT), and pronuclear stage transfer (PROST).

#### **Service Maximum:**

- **\$2,000** per lifetime for covered services and supplies related to infertility treatment.

#### **Not Covered:**

- 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.

#### **See Also:**

*Prior Approval, page 42.*

### **Standard Plan**

#### **Covered:**

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

#### **Not Covered:**

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

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

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## Genetic Testing

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

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

**See Also:**

*Prior Approval, page 42.*

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## Hearing Services

**Covered:**

- Hearing examinations, but only to test or treat hearing loss related to an illness or injury.

**Not Covered:**

- Hearing aids.
- Routine hearing examinations.

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## Home Health Services

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

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

- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is prescribed by a physician and approved by a Wellmark case manager.

The following are covered services and supplies:

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

**Home Skilled Nursing.** Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Home skilled nursing is intended to provide a safe transition from other levels of care when medically necessary, to provide teaching to caregivers for ongoing care, or to provide short-term treatments that can be safely administered in the home setting. The daily benefit for home skilled nursing services will not exceed the daily rate for a comparable level of care in a facility setting, and annual benefits will not exceed the total amount we would pay in one year for a comparable level of care in a facility setting. 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**—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not

covered for occupational therapy supplies.

**Oxygen and Equipment** for its administration.

**Parenteral and Enteral Nutrition.**

**Physical Therapy.**

**Prescription Drugs and Medicines** administered in the vein or muscle.

**Prosthetic Appliances and Braces.**

**Speech Therapy.**

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

**See Also:**

*Case Management*, page 43.

*Precertification*, page 41.

## Home/Durable Medical Equipment

**Covered:** Equipment that meets all of the following requirements:

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

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

**Service Maximum:**

- **Two pairs** of compression garments per benefit year.

**See Also:**

*Medical and Surgical Supplies* later in this section.

*Orthotics* later in this section.

*Personal Convenience Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 35.

*Prosthetic Appliances* later in this section.

*Prior Approval*, page 42.

## Hospice Services

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

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

**Service Maximum:**

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

**See Also:**

*Precertification*, page 41.

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## 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.

### Service Maximum:

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

### Not Covered:

- Residential Treatment Facility. This type of facility provides treatment for severe, persistent, or chronic mental health conditions or chemical dependency that meets all of the following criteria:

- Treatment is provided in a 24-hour residential setting.
- Treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision.
- Treatment includes training in basic skills such as social skills and activities of daily living.
- Treatment does not require daily supervision of a physician.

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## Illness or Injury Services

**Covered:** Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.

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

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

### See Also:

*Precertification*, page 41.

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## Inhalation Therapy

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

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## Maternity Services

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

terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

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

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

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

If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

**See Also:**

*Coverage Change Events*, page 59.

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## Medical and Surgical Supplies

**Covered:** Medical supplies and devices such as:

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

**Not Covered:**

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

**See Also:**

*Home/Durable Medical Equipment* earlier in this section.

*Orthotics* later in this section.

*Personal Convenience Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 35.

*Prosthetic Appliances* later in this section.

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## Mental Health Services

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

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

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

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

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

**Service Maximum:**

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

**Not Covered:**

- Certain disorders related to early childhood, such as academic underachievement disorder.

- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual identification or gender disorders.
- Residential facility services.

**See Also:**

*Hospitals and Facilities* earlier in this section.

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## **Morbid Obesity Treatment**

**Covered:** Weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of this summary plan description, or call the Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number on your ID card or visit our Web site at [www.wellmark.com](http://www.wellmark.com).

**Service Maximum:**

- **\$10,000** per lifetime.

**Not Covered:**

- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

**See Also:**

*Weight Reduction Drugs* later in this section.

*Prior Approval*, page 42.

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## **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.

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## **Musculoskeletal Treatment**

### **Premium Plan**

**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.

### **Standard Plan**

**Not Covered.** Musculoskeletal treatment is not covered under the Standard Plan.

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## **Nonmedical Services**

**Not Covered:** Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, and educational or recreational therapy or services or supplies that are nonmedical.

---

## **Occupational Therapy**

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

**Not Covered:**

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

---

## **Orthotics**

**Not Covered:** Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or

examinations to prescribe or fit such devices.

**See Also:**

*Home/Durable Medical Equipment* earlier in this section.

*Personal Convenience Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 35.

*Prosthetic Appliances* later in this section.

## Physical Therapy

**Covered.**

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

## Physicians and Practitioners

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

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

**Audiologists.**

**Chiropractors.** These providers are covered under the Premium Plan only.

**Service Maximum:**

- \$500 per benefit year for chiropractic services, including x-ray services,

**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.**

**Not Covered:**

- Athletic Trainers.
- Chiropractors. These providers are not covered under the Standard Plan

**See Also:**

*Choosing a Provider*, page 37.

## Prescription Drugs

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

Prescription drugs and medicines covered under this medical benefits plan include:

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

- Contraceptive devices.
- Implanted contraceptives.
- Injected contraceptives.

**Drugs and Biologicals.** Certain drugs and biologicals approved by the Food

and Drug Administration are covered under this medical benefits plan. This includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

**Infertility Prescription Drugs.**

Infertility prescription drugs are covered under the Premium Plan only.

**Intravenous Administration.**

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

**Nicotine Dependence.** Prescription drugs and devices used to treat nicotine dependence are covered under the prescription drug plan and not under this medical benefits plan. However, related medical evaluations are covered under this medical benefits plan.

**Specialty Self-Administered Drugs.** Specialty self-administered drugs are typically used for treating or managing chronic illnesses. Some of these drugs are taken orally (tablets, capsules, inhalations, etc.) while others require self-administration via injection. Specialty self-administered drugs often require special handling (e.g., refrigeration) and may not be available from a retail pharmacy.

**Not Covered:**

- Contraceptives absorbed through the skin.
- Growth hormones.
- Infertility prescription drugs. These drugs are not covered under the Standard Plan.
- Insulin. See *Prescription Drug Plan* later in this section.
- Oral contraceptives. See *Prescription Drug Plan* later in this section.
- Prescription drugs and devices used to treat nicotine dependence, which are covered under the prescription drug plan. You are also not covered for

psychotherapy, and x-ray and lab services related to nicotine dependence.

**See Also:**

*Prior Authorization*, page 44.

**Preventive Care**

**Premium Plan**

**Covered:**

- Physical examinations and related preventive services such as:
  - Gynecological examinations.
  - Immunizations.
  - Mammograms.
  - Pap smears.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

**Service Maximum:**

- Well-child care until the child reaches age seven.
- **One** routine mammogram per benefit year.
- **One** routine Pap smear per benefit year.
- **\$200** per benefit year for routine physical examinations and related preventive services. This limit includes:
  - **One** routine gynecological examination per benefit year.

This limit does not include:

- Colonoscopies.
- Immunizations.
- Mammograms.

- Pap smears.
- Well-child care.

**Not Covered:**

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

**See Also:**

*Hearing Services* earlier in this section.

*Vision Services* later in this section.

**Standard Plan**

**Covered:** The following routine services when received from PPO providers:

- Physical examinations and related preventive services such as:
  - Gynecological examinations.
  - Immunizations.
  - Mammograms.
  - Pap smears.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

**Service Maximum:**

- Well-child care until the child reaches age seven.
- **One** routine mammogram per benefit year.
- **One** routine Pap smear per benefit year.

- **\$200** for routine physical examinations and related preventive services per benefit year. This limit includes:

- **One** routine gynecological examination per benefit year.

This limit does not include:

- Colonoscopies.
- Immunizations.
- Mammograms.
- Pap smears.
- Well-child care.

**Not Covered:**

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.
- The following routine services when received from non-PPO providers:
  - Colonoscopies.
  - Gynecological examinations.
  - Immunizations.
  - Mammograms.
  - Pap smears.
  - Physical examinations including related services.
  - Well-child care.

**See Also:**

*Hearing Services* earlier in this section.

*Vision Services* later in this section.

**Prosthetic Appliances**

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

Also covered are braces, which are rigid or semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include

elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

**Not Covered:**

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

**See Also:**

*Home/Durable Medical Equipment* earlier in this section.

*Medical and Surgical Supplies* earlier in this section.

*Orthotics* earlier in this section.

*Personal Convenience Items* in the section *General Conditions of Coverage, Exclusions, and Limitations*, page 35.

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## Reconstructive Surgery

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

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

**See Also:**

*Prior Approval*, page 42.

*Cosmetic Services* earlier in this section.

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## Self Help Programs

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

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## Sleep Apnea Treatment

**Covered:** Obstructive sleep apnea diagnosis and treatments.

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

**See Also:**

*Prior Approval*, page 42.

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## Speech Therapy

**Covered:** Rehabilitative speech therapy treatment.

**Not Covered:**

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

**See Also:**

*Prior Approval*, page 42.

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## Surgery

**Covered.** This includes the following:

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

**See Also:**

*Dental Services* earlier in this section.

*Reconstructive Surgery* earlier in this section.

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## Temporomandibular Joint Disorder (TMD)

### Premium Plan

**Covered.**

#### Service Maximum:

- **\$3,000** per lifetime for treatment.

**Not Covered:** Dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

### Standard Plan

**Not Covered.** Treatment of temporomandibular joint disorder is not covered under the Standard Plan.

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## Transplants

**Covered:**

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

Transplants are subject to Case Management.

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

#### Service Maximum:

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

**Not Covered:**

- Expenses of transporting a living donor.

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

**See Also:**

*Prior Approval*, page 42.

*Case Management*, page 43.

*Travel or Lodging Costs* later in this section.

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## Travel or Lodging Costs

**Covered:** Travel and lodging costs when related to a transplant for the covered transplant recipient and one companion, or two companions if the recipient is a covered dependent.

#### Service Maximum:

- **\$10,000** per transplant for lodging and meals.

**See Also:**

*Transplants* earlier in this section.

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## Vision Services

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

**Not Covered:**

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

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## Wigs or Hair Pieces

**Covered:** Wigs and hair pieces are covered but only when related to hair loss resulting from medical treatment, such as chemotherapy treatment.

**Service Maximum:**

- **\$400** per lifetime.

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## 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.

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## Prescription Drug Plan

You are covered for most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription" and meet the following criteria:

- Prescribed by a practitioner who is legally authorized to prescribe.
- Dispensed by a recognized licensed retail pharmacy, a contracting specialty pharmacy, or through the mail order drug program.
- Drugs that are medically necessary for your condition. See *Medically Necessary*, page 33.

Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected prescription drugs. Devices and implants are never covered.

- The drug's price is not significantly lower than that of the brand name drug.

**Prescription Maximum:**

- Retail Prescriptions. A 30-day supply.
- Mail Order Prescriptions. A 90-day supply.

**See Also:**

*Prior Authorization*, page 44.

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## Branded Generic Prescription Drugs

**Covered:** Branded generics that are substitute prescription drugs with the same active chemical ingredients as brand name drugs.

A branded generic may be treated as a brand name drug throughout the industry for one of the following reasons:

- It is not made under the original patent, but the manufacturer traditionally makes brand name drugs instead of generics; or

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## Brand Name Prescription Drugs

**Covered:** A prescription drug patented by the original manufacturer.

**Prescription Maximum:**

- Retail Prescriptions. A 30-day supply.
- Mail Order Prescriptions. A 90-day supply.

**See Also:**

*Prior Authorization*, page 44.

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## Chemical Dependency Drugs

**Covered.**

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## Contraceptives

**Covered:** Oral contraceptives and contraceptives absorbed through the skin.

**Not Covered:** Contraceptive devices and implants.

**See Also:**

*Prescription Drugs, page 23.*

**Convenience Packaging**

**Not Covered:** When the cost exceeds the cost of the drug when purchased in its normal container.

**Cosmetic Drugs**

**Not Covered:** Prescription drugs that are primarily to improve your natural appearance.

**Drugs that are Lost, Damaged, Stolen, or Used Inappropriately**

**Not Covered.**

**Drugs You Abuse**

**Not Covered:** Drugs determined to be abused or otherwise misused by you.

**Generic Prescription Drugs**

**Covered:** Prescription drugs with active therapeutic ingredients chemically identical to a brand name drug. These drugs are often available at a lower cost than their brand-name equivalent.

**Prescription Maximum:**

- A 90-day supply.

**See Also:**

*Prior Authorization, page 44.*

**Immunization Agents**

**Covered:** Vaccinations received at a retail pharmacy.

**Not Covered:** Biological products for allergy immunization, or biological serum, blood, blood plasma, and other blood products or fractions.

**See Also:**

*Prescription Drugs, page 23.*

**Impotence Drugs**

**Covered:** If the condition is the result of a physical illness or injury.

**See Also:**

*Prior Authorization, page 44*

**Infertility Drugs**

**Not Covered:** Prescription drugs necessary to treat male or female infertility.

**See Also:**

*Prescription Drugs, page 23.*

**Insulin and Supplies**

**Covered:** Insulin, needles, syringes, test strips, and lancets.

**Irrigation Solutions and Supplies**

**Not Covered.**

**Nutritional and Dietary Supplements**

**Covered:**

- Prenatal vitamins.

**Not Covered:** Nutritional or dietary supplements including, but not limited to:

- Special dietary formulas.
- Herbal products.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

**Over-the-Counter Products**

**Not Covered:** Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the Customer Service number on your ID card.

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## Sales Tax

**Covered:** If you purchase a covered prescription drug that is subject to a state sales tax, the sales tax amount is covered.

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## Self-Help Drugs

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

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## Specialty Self-Administered Drugs

**Covered:** Specialty self-administered drugs purchased from a retail pharmacy or from a contracting specialty pharmacy.

Specialty self-administered drugs are typically used for treating or managing chronic illnesses. Some of these drugs are taken orally (tablets, capsules, inhalations, etc.) while others require self-administration via injection. Specialty self-administered drugs often require special handling (e.g., refrigeration) and are not available through the mail order drug program.

**Prescription Maximum:** A 30-day supply.

### Not Covered:

- Growth hormones.
- Specialty self-administered drugs administered in the office of a physician.

To determine if a particular drug is considered a specialty self-administered drug, visit our Web site at [www.wellmark.com](http://www.wellmark.com) or call the Customer Service number on your ID card.

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## Therapeutic Devices or Medical Appliances

**Not Covered:** Therapeutic devices or medical appliances including hypodermic needles or syringes and home/durable medical equipment. This exclusion does not apply to needles and syringes for insulin.

### See Also:

*Prescription Drugs*, page 23.

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## Tobacco Dependency Drugs

**Covered.**

**Prescription Maximum:** \$400 per lifetime for tobacco dependency drugs.

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## Weight Reduction Drugs

**Covered.**

### See Also:

*Prior Authorization*, page 44.

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## Prescription Purchases Outside the United States

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

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

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## Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. In addition, benefits for certain drugs are limited by month, benefit year, or lifetime, based on Wellmark's medical necessity criteria. For a list of these limited drugs, visit our Web site at [www.wellmark.com](http://www.wellmark.com) or check with your pharmacist or physician.

However, the quantity limitation may be waived for certain prescriptions packaged in a dose exceeding the maximum quantity covered under this prescription drug plan (for example, oral contraceptives).

However, the quantity limitation may be waived for certain prescriptions packaged in

a dose exceeding the maximum quantity covered under this prescription drug plan for example, oral contraceptives). To determine if the quantity limitation may be waived, call the Customer Service number on your ID card.

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## **Refills**

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

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

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

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

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



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## 4. General Conditions of Coverage, Exclusions, and Limitations

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

### Conditions of Coverage

#### Medically Necessary

A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

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

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
  - Any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and

considered effective for the patient's illness, injury or disease.

- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

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

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

- You receive the services from a nonparticipating provider; or
- You receive the services from a PPO or participating provider in Iowa and South Dakota 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 Iowa and South Dakota that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

### **Member Eligibility**

Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 55.

### **General Exclusions**

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

#### **Investigational or Experimental**

You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine.

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

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

- The health improvement is attainable outside the investigational settings.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other Blue Cross and Blue Shield member organizations. Copies of the evaluation criteria and the reference manual information for a specific service, supply, device, or drug are available upon request.

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

- You receive the services from a nonparticipating provider; or
- You receive the services from a PPO or participating provider in Iowa and South Dakota 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 Iowa and South Dakota that Wellmark determines to be investigational or experimental. This is

true even if the provider does not give you any written notice before the services are rendered.

**Complications of a Noncovered Service**

You are not covered for a complication resulting from a noncovered service, supply, device, or drug.

**Nonmedical Services**

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

**Personal Convenience Items**

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

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

**Provider Is Family Member**

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

**Covered by Other Programs or Laws**

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

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health plan, you would not be charged.
- Prescription drug claims are submitted to another insurance carrier. We will not reimburse you for amounts that are unpaid by your other carrier, including deductible, coinsurance, or copayments.

- You require services or supplies for an illness or injury sustained while on active military status.

**Workers' Compensation**

You are not covered for services or supplies 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 this group health plan. These amounts are not credited toward your out-of-pocket maximum. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a service or prescription maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered*, page 15.
- If you receive total benefits in an amount that reaches a lifetime benefits maximum, you are no longer eligible for benefits under this group health plan. See *Lifetime Benefits Maximum*, page 7, and *At a Glance—Covered and Not Covered*, page 9.
- If you do not obtain precertification for medical services, benefits can be reduced or denied. You are responsible for these benefit reductions only if you are responsible (not your provider) for notification. A PPO provider may handle

notification requirements for you. See *Notification Requirements and Care Coordination*, page 41.

- If you do not obtain prior authorization for prescription drugs, benefits can be reduced or denied. See *Notification Requirements and Care Coordination*, page 41.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 37, and *Factors Affecting What You Pay*, page 47. Examples of charges that depend on the type of provider include but are not limited to:
  - Any difference between the provider's amount charged and our amount paid is your responsibility if you receive services from a nonparticipating provider.

# 5. Choosing a Provider

## Medical Benefits Plan

### PPO Providers

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

### Non-PPO Providers

Non-PPO providers are defined as participating and nonparticipating providers.

### Participating Providers

If you are unable to utilize a PPO provider, it is usually to your advantage to visit what we call a *participating provider*.

Participating providers participate with a Blue Cross and/or Blue Shield Plan, but not with a PPO.

### Nonparticipating Providers

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

See *What You Pay*, page 3 and *Factors Affecting What You Pay*, page 47.

### Provider Status

To determine if a provider participates with this medical benefits plan, ask your provider, visit our Web site at [www.wellmark.com](http://www.wellmark.com), or [www.bcbs.com](http://www.bcbs.com), refer to your provider directory (a separate document that's available, without charge), or call **800-810-BLUE**.

For types of providers that may be covered under this medical benefits plan, see *Hospitals and Facilities*, page 20 and *Physicians and Practitioners*, page 23.

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

Always carry your ID card and present it when you receive services. Information on it, especially the ID number, is required to process your claims correctly.

Pharmacies do not participate with this medical benefits plan.

### Specialists

If you require services from a specialist, you should utilize a PPO provider whenever possible. However, if you require services that are not available from a PPO specialist within 30 miles of your home address, you may utilize a non-PPO specialist who has expertise in diagnosing and treating your condition. **Please note:** Wellmark must approve non-PPO specialist services before you receive the services. Even after you receive approval, you are still responsible for complying with notification requirements. See *Notification Requirements and Care Coordination*, page 41.

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

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

### Services Outside Iowa and South Dakota

Whenever possible, before receiving services outside Iowa and South Dakota, 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](http://www.bcbs.com).

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

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside Iowa and South Dakota similar to those you would have within Iowa and South Dakota 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 may not be available in some states. In this case, when you receive covered services from a non-BlueCard PPO provider, you will receive the same advantages as when you receive covered services from a BlueCard PPO provider.

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 Iowa and South Dakota, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the providers.

When you receive covered services from BlueCard providers outside Iowa and South Dakota, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 41.

### 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.

## Prescription Drug Plan

### Choosing a Pharmacy

Pharmacies that participate with the network used by this prescription drug plan are called participating pharmacies. Pharmacies that do not participate with the network are called nonparticipating pharmacies.

To determine if a pharmacy is participating, ask the pharmacist, consult the directory of participating pharmacies (a separate document available without charge), visit our Web site at [www.wellmark.com](http://www.wellmark.com), or call us.

This prescription drug plan allows you to purchase covered prescription drugs from almost any pharmacy you choose. However, you will usually pay more for prescription drugs when you purchase them from nonparticipating pharmacies. We recommend you:

- Fill your prescriptions at a participating retail pharmacy, a contracting specialty pharmacy, or through the mail order drug program. See *Mail Order Prescription Program* later in this section.
- Advise your physician that you are covered under this prescription drug plan.
- Always present your ID card when filling prescriptions. Your ID card enables participating pharmacists to access your benefits information.

### Advantages of Visiting Participating Pharmacies

When you fill your prescription at participating pharmacies:

- You will usually pay less. If you use a nonparticipating pharmacy, you must pay the amount charged at the time of

purchase, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.

- The participating pharmacist can check whether your prescription is subject to prior authorization or quantity limits.
- The participating pharmacist can access your benefit information, verify your eligibility, check whether the prescription is a benefit under this Prescription drug plan prescription drug plan, list the amount you are expected to pay, and suggest generic alternatives.

### Always Present Your ID Card

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

- You must pay the full amount charged at the time you receive your prescription, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- You must file your claim to be reimbursed. See *Claims*, page 73.

### Mail Order Prescription Program

#### Registering for the Program

You must register as a Walgreens Mail Service User in order to fill your prescription(s) through the mail order drug program. You may register by:

- Completing a registration and prescription order form at our Web site, [www.wellmark.com](http://www.wellmark.com); or
- Calling Walgreens Mail Service at **866-611-5961**.

### **Initial Order**

Orders may be placed by mail or faxed from your physician's office.

Mail your original prescription(s), payment, and the completed registration and prescription order form to:

Walgreens Mail Service  
P.O. Box 29061  
Phoenix, AZ 85038-9061

For orders placed by mail, you may pay by credit card, check, or money order. Do not send cash.

Or ask your physician to fax your prescription to Walgreens Mail Service at **800-332-9581**. Physician fax order forms are available at our Web site, [www.wellmark.com](http://www.wellmark.com) or by calling the Customer Service number on your ID card. Faxed prescriptions are only valid when faxed from your physician's office.

If you place your order by fax, you must pay by credit card.

Prescription(s) are typically delivered within 10 to 14 days after the order is received.

### **Refill Orders**

You may place refill orders online at [www.wellmark.com](http://www.wellmark.com), by calling **800-797-3345**, or by mailing a completed Walgreens refill request slip to:

Walgreens Mail Service  
P.O. Box 29061  
Phoenix, AZ 85038-9061

Each time you submit a prescription order through the mail order program, in addition to your prescription, you will also receive a reorder form and envelope and a refill request slip notifying you of when you can request a refill and the number of refills remaining (if any).

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## 6. Notification Requirements and Care Coordination

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### Medical Benefits Plan

Many services require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical.

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

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 81. Also see *Authorized Representative*, page 85.

### Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. This notification requirement is mandatory; however, it does not apply to maternity or emergency services.
Applies to	Acute Rehabilitation Facilities Home Health Services Home Infusion Therapy Hospice Services Nursing Facilities Facilities Outside Iowa or South Dakota
Person Responsible	PPO providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for notifying us if: <ul style="list-style-type: none"><li>■ You are admitted to a facility outside Iowa or South Dakota;</li><li>■ You receive any of the services listed above from a non-PPO provider.</li></ul>
Process	When you, instead of your PPO provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: <ul style="list-style-type: none"><li>■ 72 hours in a medically urgent situation;</li><li>■ 15 days in a non-medically urgent situation.</li></ul>

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Importance	<p>If you choose to obtain any service subject to precertification even though we were unable to certify its medical necessity, you will be responsible for the charges.</p> <p>Even if a service is medically necessary and otherwise covered, without precertification, benefits will be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction will not exceed \$500 per admission. See <i>Maximum Allowable Fee</i>, page 49. You are subject to this benefit reduction only if you (instead of your PPO provider) are responsible for notification.</p> <p>Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See <i>What You Pay</i>, page 3.</p>
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### **Prior Approval**

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Purpose	<p>Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical plan before you receive services. This notification is recommended.</p>
Applies to	<p>The most common services for which we recommend prior approval include, but are not limited to, the following list. For a complete list of services subject to prior approval, visit <a href="http://www.wellmark.com">www.wellmark.com</a> or call the Customer Service number on your ID card.</p> <ul style="list-style-type: none"> <li>Genetic Testing</li> <li>Home/Durable Medical Equipment</li> <li>Infertility Procedures including all forms of in vitro fertilization</li> <li>Obstructive Sleep Apnea Treatment</li> <li>Reconstructive Surgery</li> <li>Speech Therapy</li> <li>Transplants</li> <li>Weight Reduction Surgery</li> </ul>
Person Responsible	<p>PPO providers in the states of Iowa and South Dakota request prior approval for you. You are responsible for prior approval if:</p> <ul style="list-style-type: none"> <li>■ You are admitted to a facility outside Iowa or South Dakota;</li> <li>■ You receive the care from a non-PPO provider.</li> </ul>
Process	<p>When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form.</p> <p>Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request by mailing the decision to the most current address on record for both you and your provider within:</p> <ul style="list-style-type: none"> <li>■ 72 hours in a medically urgent situation.</li> <li>■ 15 days in a non-medically urgent situation.</li> </ul>

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Importance	<p>If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and service maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, it may not be covered.</p> <p>Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits plan in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or a new medical benefits plan), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended.</p> <p><b>Note:</b> An admission to a facility outside Iowa or South Dakota to receive a service for which prior approval is recommended is also subject to precertification. See <i>Precertification</i> earlier in this section.</p>
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### Continued Stay Review

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Purpose	Continued stay review helps determine whether ongoing care is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	<p>Inpatient Facility Admission</p> <p>Home Health Services</p> <p>Home Infusion Therapy</p> <p>Hospice Services</p>
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary.
Importance	<p>Wellmark may require a change in the level or place of service in order to continue providing benefits.</p> <p>If we determine that your current level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.</p>

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### Case Management

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Purpose	Case management is a process of considering alternative treatments for members with severe illnesses or injuries that require costly, long-term care. Depending on the individual circumstances, a hospital may not be the most appropriate setting for treatment.
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Applies to	<p>Examples where case management might be appropriate include but are not limited to:</p> <p>Brain or Spinal Cord Injuries</p> <p>Cystic Fibrosis</p> <p>Degenerative Muscle Disorders</p> <p>Hemophilia</p> <p>Home Health Services</p> <p>Pregnancy (high risk)</p> <p>Transplants</p>
Person Responsible	<p>You, your physician, and the health care facility can work with Wellmark's case managers to identify and arrange alternative treatment plans to meet special needs. Wellmark may initiate a request for case management.</p>
Process	<p>Wellmark's case managers try to identify alternative settings or treatment plans, provided costs do not exceed those of an inpatient facility. A benefit program is tailored to the circumstances of the case.</p> <p>Even if a service is not covered or is subject to a specific limitation, Wellmark may waive exclusions or limitations with the agreement of its medical director.</p> <p>If your current level or setting of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified at least 24 hours before benefits end.</p>
Importance	<p>Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.</p>

**Prescription Drug Plan**

**Prior Authorization of Drugs**

Purpose	<p>Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary.</p>
Applies to	<p>Prior authorization is required for a number of particular drugs. Visit <a href="http://www.wellmark.com">www.wellmark.com</a> or check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.</p>

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**Process**      **Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before filling your prescription. Nonparticipating pharmacists will fill a prescription without prior authorization but you will be responsible for paying the charge.**

**Wellmark will respond to a prior authorization request within:**

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

**Calls received after 4:00 p.m. are considered the next business day.**

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**Importance**      **If you purchase a drug that requires prior authorization but do not request prior authorization, you are responsible for paying the entire amount charged.**

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## 7. Factors Affecting What You Pay

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

### Medical Benefits Plan

#### Benefit Year

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

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

The benefit year is important for calculating:

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

#### How Coinsurance is Calculated

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

**PPO Providers in Iowa and South Dakota and All Non-PPO Providers**  
Excluding PPO office and independent lab services, coinsurance is calculated using the payment arrangement amount after the following amounts (if applicable) are subtracted from it:

- Deductible.
- Certain copayments.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

#### BlueCard PPO Providers Outside Iowa and South Dakota

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

- The amount charged for the covered service, or
- The payment arrangement or negotiated price that the local Blue Cross or Blue Shield Plan passes on to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Certain copayments.
  - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

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

or under-estimates of past prices; however, the amount you pay is considered a final price.

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

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 33.

Statutes in a few states may require the local Blue Plan to use a basis for calculating your payment obligation for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. In such a case, Wellmark would calculate your payment obligation in accordance with the applicable state statute in effect at the time you received your care. For more information, see *BlueCard Program*, page 38.

## PPO Providers

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

- The PPO amounts for the following are waived for certain covered services.
  - Deductible.
  - Coinsurance.
- The PPO amounts for the following are less than the non-PPO amounts.
  - Deductible.
  - Coinsurance.
  - Out-of-Pocket Maximum.
- These providers agree to accept Wellmark's payment arrangements or

payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.

- The health plan payment is sent directly to the provider.

## Non-PPO Providers

### Participating Providers

Participating providers participate with a Blue Cross and/or Blue Shield Plan, but not with a PPO. When you receive services from participating providers:

- These providers agree to accept Wellmark's payment arrangements or payment arrangements or negotiated prices of the Blue Cross and Blue Shield Plan with which the provider contracts. These payment arrangements may result in savings.
- The health plan payment is sent directly to the provider.

### Nonparticipating Providers

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

- You are responsible for any difference between the amount charged and our payment for a covered service. In the case of services received outside Iowa or South Dakota, our maximum payment for services by a nonparticipating provider may be the lesser of Wellmark's maximum allowable fee or the amount allowed by the Blue Cross or Blue Shield Plan in the state where the provider is located. See *Services Outside the Wellmark Service Area*, page 38.
- The health plan does not make claim payments directly to these providers.

You are responsible for ensuring that your provider is paid in full.

- The health plan payment for nonparticipating hospitals, M.D.'s, and D.O.'s in Iowa is made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider (plus any billed balance you may owe).

## Amount Charged and Maximum Allowable Fee

### Amount Charged

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

### Maximum Allowable Fee

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

For professional services, Wellmark utilizes the Resource Based Relative Value System methodology. This approach assigns a Relative Value Unit to a majority of procedures. The Relative Value Unit is then multiplied by a Wellmark established conversion factor or dollar value to create a Maximum Allowable Fee. This fee schedule is implemented statewide for all of the Wellmark's contracted professional providers and is updated annually in July.

## Payment Arrangements

### Payment Arrangement Savings

Payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Network Savings*, which reflects the amount you save on a claim by receiving services from a participating or PPO provider. For the majority of services,

the savings reflects the actual amount you save on a claim. However, depending on many factors, the amount we pay a facility could be different from the covered charge. Regardless of the amount we pay a facility, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.

- *Amount Not Covered*, which reflects the portion of provider charges not covered under this health plan and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a service maximum, benefit year maximum, or lifetime benefits maximum; reductions for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 33.
- *Amount Paid by Health Plan*, which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting the following amounts (if applicable) from the amount charged:
  - Deductible.
  - Coinsurance.
  - Copayment.
  - Amounts representing any general exclusions and conditions.
  - Network savings.

### Payment Method for Services

Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not

allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. PPO and participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

## Prescription Drug Plan

### Benefit Year

A benefit year is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1.

The benefit year is important for calculating:

- Deductible.

### Tiers

The Wellmark Drug List identifies which tier a drug is on:

**Tier 1** consists of most generic drugs. Tier 1 drugs have the lowest payment obligation.

**Tier 2** consists of selected brand name drugs and branded generic drugs. Many drugs appear on this tier because they have no generic equivalent. Tier 2 drugs have a higher payment obligation than Tier 1 drugs.

**Tier 3** consists of selected brand name drugs. Many drugs appear on this tier because they have reasonable alternatives on Tier 1 or Tier 2. Tier 3 drugs have a higher payment obligation than Tier 2 drugs.

**Tier 4** consists of other selected brand name drugs. Many drugs appear on this tier because there are reasonable alternatives on a lower tier, or because there is no documented clinical evidence that they

provide a significant benefit over available lower-tiered alternatives. Tier 4 drugs have the highest payment obligation.

Upon introduction of an FDA-approved “A”-rated generic equivalent, the generic drug’s brand name counterpart may be moved to a higher tier.

### Generic and Brand Name Drugs

#### Generic Drug

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

#### Brand Name Drug

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

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

**Branded Generic Drug**

Branded generic drug is a substitute prescription drug with the same active chemical ingredients as a brand name drug. This category of drug is treated as a brand name drug throughout the industry for one or both of the following reasons:

- It is not made under the original patent, but the manufacturer traditionally makes brand name drugs instead of generics.

- The drug’s price is not significantly lower than that of the brand name drug.

**What You Pay**

For Tier 2, Tier 3, or Tier 4 drugs, in addition to the copayment, you may also be responsible for any cost difference between the amount charged for the Tier 2, Tier 3, or Tier 4 drug and the amount charged for the Tier 1 drug. See the following chart.

Situation	Applicable Copayment	Cost Difference Owed
Your prescription is for a generic and you purchase a generic.	Tier 1 copayment	No
Your prescription is for a drug that has an FDA-approved “A”-rated generic equivalent and your physician has not specified that you must take the brand name drug, but you choose to purchase the brand name drug.	Tier 2, 3, or 4 copayment	Yes
Your prescription is for a brand name drug and your practitioner has specified that a generic is not allowed, and the prescription must be dispensed as written.	Tier 2, 3, or 4 copayment	Yes
Your prescription is for a narrow therapeutic index brand name drug. This means that a very small change in the dosage level could cause toxic results.	Tier 2, 3, or 4 copayment	No
Your prescription is for a brand name drug and the FDA does not rate an available generic substitute for the brand name drug as “A”-equivalent.	Tier 2, 3, or 4 copayment	No

**Quantity Limitations**

The drug quantity you purchase may affect the total number of copayments that apply per prescription.

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. However, the quantity limitation may be waived for certain prescriptions packaged in a dose exceeding the maximum quantity covered under this prescription drug plan (for example, oral contraceptives). To determine if these accommodations are allowed for your prescription, call the Customer Service number on your ID card.

In addition, coverage for certain drugs are limited by month, benefit year, or lifetime. For a list of limited drugs, check with your pharmacist or physician or visit our Web site, [www.wellmark.com](http://www.wellmark.com).

**Amount Charged and Maximum Allowable Fee**

**Amount Charged**

The retail price charged by a pharmacy for a covered prescription drug.

**Maximum Allowable Fee**

The amount, established by Wellmark using various methodologies and data (such as the

average wholesale price), payable for covered drugs.

The maximum allowable fee may be less than the amount charged for the drug.

### **Participating vs. Nonparticipating Pharmacies**

If you do not purchase a covered prescription drug at a participating pharmacy, you are responsible for the amount charged for the drug at the time you fill your prescription.

Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug less your payment obligation. The maximum allowable fee may be less than the amount you paid. In other words, in addition to your payment obligation, you are also responsible for any difference in cost between what the pharmacy charges you for the drug and our reimbursement amount.

Your payment obligation for the purchase of a covered prescription drug at a participating pharmacy is the lesser of the

copayment or the amount charged for the drug.

### **Special Programs**

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

Visit our Web site at [www.wellmark.com](http://www.wellmark.com) or call us to determine whether your prescription qualifies.

### **Savings**

#### **Payment Arrangements**

The benefits manager of this prescription drug program has established payment arrangements with participating pharmacies that may result in savings.

## Medical Benefits and Prescription Drug Plan

### **Wellmark Drug List**

Most prescription drugs are covered under your prescription drug plan.

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 this medical benefits plan, or other limitations apply.

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our Web site, [www.wellmark.com](http://www.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 to its accounts, such as your plan sponsor. Your plan sponsor is to pay a monthly fee for such services.

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



## 8. Coverage Eligibility and Effective Date

### Who is Eligible

You are eligible to participate in this plan if you are a member of one of the following groups.

**Full-time Corporate Employees:** A regular, full-time employee of Casey's General Stores, Inc. for at least 90 consecutive days who is regularly scheduled to work a minimum of 35 hours per week.

**Spouse:** A husband or wife as the result of a marriage that is legally recognized in your state of residence, including common law.

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

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

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

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

- Under age 19.
- A full-time student under age 25 enrolled in an accredited educational institution. Full-time student status continues during regularly scheduled

school vacations and during extended absences for up to four months due to a physical or mental disability.

- Totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 19, or while the child was a full-time student under age 25.

If a dependent child is enrolled in the plan and is physically or mentally disabled on the date coverage would otherwise end, the child's eligibility will be extended for as long as you are covered by this plan, the disability continues, and the child continues to qualify for coverage in all aspects other than age.

You must submit proof to the plan administrator within 30 days of the date the dependent reaches the termination age. The plan may require you, at any time, to obtain a physician's statement certifying the dependent's physical or mental disability.

You may not participate in this plan as both an employee and a dependent and your dependents may not participate in this plan as a dependent of more than one employee.

**Please note:** In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 59.

### Who Pays For Your Benefits

Casey's General Stores, Inc. shares the cost of providing benefits for you and your dependents. From time to time, Casey's General Stores, Inc. may adjust the amount of contributions required for coverage. In addition, the deductibles and copayments may also change periodically. You will be notified of any changes in the cost of plan coverage before they take effect.

## Non-Tobacco Incentive

Casey's General Stores, Inc. offers a "Non-tobacco Premium Incentive" to employees and family members who do not use tobacco products. **To qualify, individuals must be "tobacco-free" for six months prior to his/her coverage effective date.** The reduced premiums will be offered once per year, each January, and to each new enrollee. The amount of the premium incentive is subject to change on an annual basis and will be announced at each plan renewal.

To qualify, participants will be required to sign an affidavit acknowledging that:

- He/She and his/her spouse (if covered under the plan) have been tobacco-free for six months prior to his/her effective date of coverage and/or plan renewal date.
- Casey's/Wellmark has access to medical records to check his/her tobacco use status.
- He/She understands that providing false information is illegal and subject to prosecution.

## When Coverage Begins

### Eligibility Date

Coverage is available on the first day of the month following 90 consecutive days of active, full-time employment. Coverage will not begin unless you are actively at work, and have properly enrolled.

Dependent coverage begins the later of your coverage start date or the first day the dependent is legally acquired (and properly enrolled).

### Enrollment Requirements

You must enroll for coverage within 31 days of your eligibility date. If you desire dependent coverage, you must also enroll any eligible dependents at this time. If you do not have any eligible dependents at the time of initial enrollment, but later acquire eligible dependents, you must enroll the

dependent(s) within 31 days of the date you acquire them.

To enroll, you must complete and return any required forms within the applicable time period. You may be required to obtain and provide your employer with a Social Security number for each covered dependent. If you do not complete a written application within 31 days of your eligibility date, you and your family members will not be eligible to enroll unless you do so within 31 days of a subsequent special enrollment event or qualifying change in status.

If you have family coverage, you should notify your employer of any newborn children. However, your newborn child will automatically be covered if the plan administrator receives a medical claim for the newborn and you pay any required contribution. If you do not pay the required contribution, the newborn's coverage will terminate at the end of the 31<sup>st</sup> day following birth.

If you have single coverage, your newborn child will be automatically covered at birth through the first 31 days. To continue coverage for the newborn beyond 31 days, you must notify your employer of the birth and pay any required contribution. If you do not pay the required contribution, the newborn's coverage will terminate at the end of the 31<sup>st</sup> day following birth.

Beyond 31 days, claims for maternity expenses will not be considered sufficient notification in order for newborn coverage to continue.

## Preexisting Condition Exclusion Period

You may be required to wait a specified time from your enrollment date before benefits are available for any medical services you receive for a preexisting condition.

The enrollment date is the earlier of the first day of coverage or, if there is a waiting period, the first day of the waiting period. For late enrollees, the enrollment date is the first day of coverage.

The preexisting condition exclusion period is 12 consecutive months from the enrollment date, minus any period of prior creditable coverage.

### **Preexisting Condition**

A preexisting condition is an illness, injury, medical, surgical, or other condition for which medical advice, diagnosis, or treatment was recommended or received within the six months ending on your enrollment date. Pregnancy is not considered a preexisting condition.

### **When Exclusion Period Applies**

A preexisting condition exclusion period applies if the member has a preexisting condition.

When a preexisting condition exclusion period applies, it begins on the enrollment date.

### **Prior Creditable Coverage**

Prior creditable coverage reduces the preexisting condition exclusion period by the amount of time you had the prior coverage provided there was no break in coverage of 63 days or more. For instance, if you were covered by another medical benefits plan (without a break of 63 days or more) for the three-month period before your enrollment date under this medical benefits plan, and if this plan includes a 12-month preexisting condition exclusion period, your preexisting condition exclusion period would be reduced to nine months.

If an eligible dependent has more prior creditable coverage than the plan member, the dependent's preexisting condition exclusion period is reduced by his or her own period of prior creditable coverage.

If you have a newborn child or adopt a child prior to being covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if he or she had prior creditable coverage at birth or on the date of placement for adoption (without a break in coverage of 63 days or more).

If you have a newborn child or adopt a child while you are covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if you add him or her to your coverage within 31 days of birth, adoption, or placement in your home for adoption.

Creditable coverage means any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.

You have the right to request certification of creditable coverage from the carrier or administrator of your prior coverage. Other types of coverage besides a group health plan may qualify as prior creditable coverage.

## Qualified Medical Child Support Order

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

A QMCSO specifies information such as:

- Your name and last known mailing address.
- The name and mailing address of the dependent specified in the court order.
- A reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined.
- The period to which the order applies.

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

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

If eligible, the dependent will have the same coverage as you or your spouse do and will be allowed to enroll immediately. You or your spouse's plan sponsor will withhold any applicable share of the dependent's

health care premiums from your compensation and forward this amount to us.

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

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

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

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

The plan sponsor is not required to maintain the dependent's coverage if:

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

## 9. Coverage Changes and Termination

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

### Coverage Change Events

You are allowed to change your enrollment elections during a benefit year if you experience a change in status. If you experience a qualifying change in your status, you may change your enrollment election within 31 days of the change in status by notifying your employer and completing and returning any required forms.

Any change in enrollment election must be consistent with your change in status. That is, you may only change your election if the change in status causes you or your dependents to gain or lose eligibility for coverage under this or another plan. The election change must correspond with the effect on coverage.

### Qualifying Change in Status

A qualifying change in status includes: marriage; divorce; legal separation; annulment of marriage; death of spouse or child; birth, adoption or placement of a child for adoption; termination or commencement of employment by you, your spouse or your child; a reduction or increase in hours of employment for you, your spouse or your child, including a switch between part-time and full-time, a strike, lockout, or commencement or return from an unpaid leave of absence; a change in dependent status for your child; a special enrollment event under the Health Insurance Portability and Accountability Act (HIPAA) for you or your dependents; you or the plan receives a QMCSO; or you, your spouse or your child becomes entitled to either Medicaid or Medicare.

### Manager Promotion (Corporate Employees)

This plan will permit an employee who is eligible, but not enrolled, to enroll for coverage or add eligible family members under the terms of this plan, if each of the following should occur:

- The employee has satisfied the 90-day waiting period and declined coverage when offered.
- The employee is promoted from an hourly position to a salary position or is promoted to any one of the following positions: Second Assistant Manager, Assistant Store Manager, Store Manager, Area Supervisor, District Manager, or Regional Manager.
- Under the terms of the plan, the employee requests enrollment into this plan not later than 31 days after the date of the promotion.

For an eligible employee who has met each of these conditions, coverage will be effective on the first day of the month following the date the completed enrollment form is received by Casey's Human Resources. The eligible employee will be subject to any applicable preexisting condition exclusion period when their coverage becomes effective, including application of any creditable coverage.

### Changing Plan Options

If you experience a qualifying change in status, you can elect to change from the Premium Plan to the Standard Plan, or vice versa. To do so, you must complete and return any required forms within 31 days of the qualifying change in status. The plan option change will be effective on the first of the month following the date the change is received by Casey's Human Resources.

## Special Enrollment Events

If you decline coverage under this plan for yourself or your dependents because of other health plan coverage, you must provide written notice that you are declining coverage due to the existence of other coverage.

If such other health plan coverage is subsequently terminated due to a loss of eligibility for such coverage (loss of eligibility does not include a loss due to: failure to pay premiums when due; failure to exhaust COBRA continuation coverage, if elected; or causes such as making a fraudulent claim or misrepresentation); or termination of any company contributions for such coverage, then you and or your eligible dependents may enroll in this plan.

To enroll, you must notify your employer and complete and return any required forms within 31 days of the termination of the other health plan coverage.

In addition, if you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you and/or your eligible dependents may enroll in this plan. To enroll, you must notify your employer and complete and return any required forms within 31 days of the date of the marriage, birth, adoption, or placement for adoption.

Newborns, adopted children, and children placed for adoption are covered retroactive to the date of birth, adoption, or placement for adoption.

## Late Enrollees

If you do not enroll within 31 days of your eligibility date or a special enrollment event, you and your dependents will not be eligible to enroll unless you experience a qualifying change in status as outlined in earlier in this section.

## Requirement to Notify Plan Sponsor

You must notify your plan sponsor within 31 days of an event that changes the coverage status of members. If you do not provide

timely notification of an event that requires you to remove an affected family member, your coverage may be terminated.

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

Your group health plan will fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of the plan conflicts with USERRA, the conflicting provision will not apply. All other benefits and exclusions of the group health 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 to a covered employee and the employee's covered dependents during a period of the employee's active service or training with any of the uniformed services. The plan provides that a covered employee may elect to continue coverages in effect at the time the employee is called to active service. The maximum period of coverage for an employee and the covered employee's dependents under such an election shall be the lesser of:

- The 24-month period beginning on the date on which the covered employee's absence begins; or
- The period beginning on the date on which the covered employee's absence 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 eight 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 eight 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 (2) years.

A covered employee who elects to continue health plan coverage under the plan during a period of active service in the uniformed services 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 employee who performs service in the uniformed services 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 by reason of service in the uniformed services, the preexisting condition exclusion and 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. The waiver of the preexisting condition exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the uniformed services.

*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 employee called to a period of active service in the uniformed service, you should check with the plan administrator for a more complete explanation of your rights and obligations under USERRA.

## Coverage Termination

The following events terminate your coverage eligibility.

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

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

## When Coverage Ends

Your coverage ends the earliest of: the end of the month in which your employment with Casey's General Stores, Inc. ends; the end of the last pay period for which a

contribution was made; the end of the month in which you are no longer eligible to participate in this plan; the end of the month in which you are laid off; or the date this plan terminates or is amended to terminate coverage for a class of employees of which you are a member.

Coverage for your dependents ends the earliest of: the date your coverage ends; the end of the month in which a dependent no longer meets the eligibility requirements; the end of the last pay period for which a contribution was made; or the date this plan terminates.

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

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

### **Medical Leave**

If you are on an approved medical leave of absence, eligibility may continue for 90 days following the date the leave began if you pay any required contributions toward the cost of the coverage. Coverage continued under this provision is in addition to coverage continued under Optional Continuation of Coverage (COBRA).

### **Worker's Compensation**

If you are unable to work full-time due to a workers' compensation injury, eligibility may continue for six months following the date the leave began if you pay any required contributions toward the cost of the coverage. Coverage continued under this provision is in addition to coverage continued under Optional Continuation of Coverage (COBRA).

### **Store Replacement/Remodel**

If you are temporarily laid off due to a store replacement or remodeling, eligibility may continue for 90 days following the date the layoff began if you pay any required contributions toward the cost of the coverage. Coverage continued under this provision is in addition to coverage continued under Optional Continuation of Coverage (COBRA).

### **Reinstatement of Coverage**

If you terminate employment or lose eligible coverage under this plan and elect to continue coverage under Optional Continuation of Coverage (COBRA) while making the applicable contributions during the time you remain off work, the 90-day waiting period will be waived when you regain full-time employment with the Casey's General Stores, Inc. If your 18-month continuation period under Optional Continuation of Coverage (COBRA) is exhausted and you are later rehired, you must again satisfy the 90-day waiting period. The preexisting condition exclusion period and all accumulated benefit year and lifetime benefits maximums will apply.

If you terminate employment or lose eligible coverage under this plan and elect not to continue coverage under Optional Continuation of Coverage (COBRA), you must satisfy the 90-day waiting period beginning from the date you return to active full-time status. The preexisting condition exclusion period and all accumulated benefit year and lifetime benefits maximums will apply.

### **Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment**

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or fraudulently misrepresent or conceal a material fact in your application; or
- Your plan sponsor commits fraud or intentionally misrepresents a material

fact under the terms of this group health plan.

- You or your plan sponsor fails to make required payments to us when due, or you fail to pay any applicable amounts you owe.

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

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

## Certificate of Creditable Coverage

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

- This coverage terminates.
- You become eligible for COBRA coverage.
- You exhaust your COBRA coverage.
- You request certification of your coverage within 24 months after this coverage terminates. See *Notice*, page 92.

## Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this group health plan.

### COBRA Continuation

COBRA continuation coverage is a temporary extension of group health coverage under the plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available

when you would otherwise lose group health coverage under the plan. It can also become available to your spouse and dependent children, if they are covered under the plan, when they would otherwise lose their group health coverage under the plan. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The description of COBRA coverage contained here applies only to the group health plan benefits offered under the plan and not to any other benefits offered by your plan sponsor (such as life insurance, disability, or accidental death or dismemberment benefits). The plan provides no greater COBRA rights than what COBRA requires. Nothing in the plan is intended to expand the participant's rights beyond COBRA's requirements.

**Coverage Entitlement.** You, your spouse, and/or your dependent child(ren) will be entitled to elect COBRA if you lose your group health coverage under the plan because of a life event known as a *qualifying event*. You may be entitled to continue this coverage under COBRA for a period of 18, 29, or 36 months depending on the qualifying event that causes loss of coverage under this plan. See *Length of Coverage* later in this section.

The following are recognized qualifying events that will entitle you, your spouse, and/or your dependent child(ren) for COBRA Coverage.

You will be entitled to elect COBRA:

- If you lose your group health coverage under the plan because your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both) prior to your qualifying event; or
- Your spouse becomes divorced or legally separated from you.

Your dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the plan because any of the following qualifying events happens:

- You die;
- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct;
- You become entitled to Medicare benefits (Part A, Part B or both);
- You and your spouse become divorced or legally separated; or
- The dependent stops being eligible for coverage under the plan as a dependent child.

A child born to, adopted by, or placed for adoption with you during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA coverage for yourself. The child's COBRA coverage begins when the child is enrolled under this plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled under this plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Your child who is receiving benefits under this plan pursuant to a qualified medical child support order (QMCSO) received by your plan sponsor during your period of employment with your plan sponsor is entitled to the same rights to elect COBRA as your eligible dependent child.

If you take a Family and Medical Leave Act (FMLA) leave and do not return to work at the end of the leave or terminate coverage during the leave, you (and your spouse and dependent children, if any) will be entitled to elect COBRA if:

- They were covered under the plan on the day before the FMLA leave began or became covered during the FMLA leave; and
- They will lose coverage under the plan because of your failure to return to work at the end of the leave. This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the plan during the leave.

COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period, subject to extension or early termination, generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. For information on how long you may have COBRA coverage, see later in this section, under *Length of Coverage*.

**Qualifying Events.** After a qualifying event occurs and any required notice of that event is properly provided to your plan sponsor, COBRA coverage must be offered to each person losing coverage under the plan who is a qualified beneficiary. You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the plan is lost because of the qualifying event.

COBRA coverage is the same coverage that this plan gives to other participants or beneficiaries under the plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the plan as other participants or beneficiaries covered under the component or components of this plan elected by the qualified beneficiary,

including open enrollment and special enrollment rights. Under this plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

When the qualifying event is the end of your employment, your reduction of hours of employment, or your death, COBRA coverage will be offered to qualified beneficiaries. You need not notify your plan sponsor of any of these three qualifying events.

For the other qualifying events, a COBRA election will be available only if you notify your plan sponsor in writing within 60 days after the later of:

- The date of the qualifying event; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event.

The written notice must include the plan name or group name, your name, your Social Security Number, your dependent's name and a description of the event.

**Please note:** If these procedures are not followed or if the written notice is not provided to your plan sponsor during the 60-day notice period, you or your dependents will lose your right to elect COBRA.

**Electing Coverage.** To elect COBRA, you must complete the Election form that is part of the COBRA election notice and submit it to MedSoft Corporation. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election form from your plan sponsor. Under federal law, you must have 60 days after the date the qualified beneficiary coverage under the plan terminates, or, if later, 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event to decide whether you want to elect COBRA under the plan.

Mail the completed Election form to:

MedSoft Corporation  
3033 Campus Drive, #200  
Plymouth, MN 55441

**Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Coverage.** Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee's group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact your (former) employer for additional information. **You must contact your (former) employer promptly after qualifying for the health coverage tax credit or you will lose your special COBRA rights.**

The Election form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including email and faxed communications.

The election must be postmarked 60 days from the termination date or 60 days from the date the COBRA election notice provided at the time of the qualifying event. **Please note:** If you do not submit a completed Election form within this period, you will lose your right to elect COBRA.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election form before the due date. The plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

You do not have to send any payment with your Election form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. You and your spouse (if your spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the COBRA election notice will lose his or her right to elect COBRA coverage.

When you complete the Election form, you must notify MedSoft Corporation if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election form, immediately notify MedSoft Corporation of the date of the Medicare entitlement at the address specified above for delivery of the Election form.

Qualified beneficiaries may be enrolled in one or more group health components at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components under which he or she was covered on the day before the qualifying event. For example, if a qualified beneficiary was covered under the medical

and vision components on the day before a qualifying event, he or she may elect COBRA under the vision component only, the medical component only, or under both medical and vision (only if both components are available as a separate election option to the active employee).

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). For information on when coverage will terminate, see later in this section, under *Termination of Coverage*.

When considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied by other group health plans if you have a 63-day gap in health coverage, and election of COBRA may help not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you elect COBRA coverage and do not exhaust COBRA coverage for the maximum time available. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as coverage sponsored by the spouse's employer) within 30 days after your group health coverage under the plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get

COBRA coverage for the maximum time available.

**Length of Coverage.** When coverage is lost due to your death, your divorce or legal separation, or your dependent child losing eligibility as a dependent child, COBRA coverage can last for up to a maximum of 36 months.

When coverage is lost due to the end of your employment or reduction in hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than you as the employee) who lose coverage as a result of the qualifying event can last a maximum of 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date on which your employment terminates, COBRA coverage under the plan for your spouse and children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if you become entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when coverage is lost due to the end of your employment or reduction of hours of employment, COBRA coverage generally can last for only up to a maximum of 18 months.

**Extending Coverage.** If the qualifying event that resulted in your COBRA election was your termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your plan sponsor of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will

eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify your plan sponsor in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was your termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify your plan sponsor in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of your termination of employment or reduction of hours; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the plan as a result of your termination of employment or reduction of hours.

The written notice must include the plan name or group name, your name, your Social Security Number, your dependent's name and a description of the event.

You must also provide this notice within 60 days after your termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to your plan

sponsor during the 60-day notice period, then there will be no disability extension of COBRA coverage.

An extension of coverage will be available to your spouse and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 60 days (or, in the case of a disability extension, the 29 months) following your termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include your death, your divorce or legal separation, or a dependent child's ceasing to be eligible for coverage as a dependent under this plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. (This extension is not available under this plan when you become entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies your plan sponsor in writing of the second qualifying event within 60 days after the later of:

- The date of the second qualifying event; and
- The date on which the qualified beneficiary would lose coverage under the terms of this plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under this plan).

If these procedures are not followed or if the written notice is not provided to your plan sponsor during the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

For example, if disability ends June 10, coverage will continue through the month of July (7/31).

**Termination of Coverage.** Coverage under COBRA will end when you meet the maximum period for your qualifying event, as indicated earlier under *Length of Coverage*.

COBRA coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- The employer ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see *Extending Coverage*, earlier in this section.
- COBRA coverage may also be terminated for any reason this plan would terminate your coverage or coverage of a beneficiary not receiving COBRA coverage, such as fraud.

You must notify your plan sponsor in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. This is true only after any preexisting condition exclusions of that other plan for a preexisting condition of

the qualified beneficiary have been exhausted or satisfied.

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). Your plan sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your plan sponsor of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your plan sponsor of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Your plan sponsor will require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice to your plan sponsor that the disabled qualified beneficiary is no longer disabled. For more information about the disability extension period, see *Extending Coverage*, earlier in this section.

**Coverage Cost and Payment.** Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of

a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

All COBRA premiums must be paid by check or money order.

Your first payment and all monthly payments for COBRA coverage must be made payable to MedSoft Corporation and mailed to:

MedSoft Corporation  
3033 Campus Drive, #200  
Plymouth, MN 55441

The payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of election. This is the date the Election form is postmarked, if mailed, or the date the Election form is received by the individual at the address specified for delivery of the Election form, if hand-delivered. For more information on electing coverage, see *Electing Coverage* earlier in this section.

The first payment must cover the cost of COBRA coverage from the time coverage under the plan would have otherwise terminated up through the end of the month before the month in which you make your first payment.

For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before

December 30, the 45<sup>th</sup> day after the date of her COBRA election.

You are responsible for making sure that the amount of your first payment is correct. You may contact the plan administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and make the first payment for it.

If you do not make the first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under this plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under this plan will continue for that month without any break.

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under this plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied

and may have to be resubmitted once coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the plan.

**Health Coverage Tax Credit.** The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals may take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at **866-628-4282**. TTD/TTY callers may call toll-free at **866-626-4282**. More information about the Trade Act is also available at [www.doleta.gov/tradeact/2002act\\_index.cfm](http://www.doleta.gov/tradeact/2002act_index.cfm).

**Assistance With Questions.** Questions concerning the plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under *ERISA*, including *COBRA*, the *Health Insurance Portability and Accountability Act (HIPAA)*, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). Addresses and phone numbers of Regional and District EBSA Offices are also available through EBSA's Web site.

**Notification of Changes.** In order to protect your family's rights, you should keep MedSoft Corporation informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices sent by your plan sponsor.

**Plan Contact Information.** For additional information about you and your dependents' rights and obligations under the plan and under federal law, you should contact your plan sponsor, the plan administrator. You may obtain information about COBRA coverage on request from:

MedSoft Corporation  
3033 Campus Drive, #200  
Plymouth, MN 55441

The contact information for the plan may change from time to time. The most recent information will be included in the most recent plan documents (if you are not sure whether this is the most recent plan document, you may request the most recent one from the plan administrator or your plan sponsor).

## **Family and Medical Leave Act of 1993**

The Family and Medical Leave Act of 1993 (FMLA), requires a public employer to allow an employee with 12 months or more of service and who has worked for 1,250 hours over the previous 12 months a total of 12 weeks of leave per fiscal year for the birth of a child, placement of a child with the employee for adoption or foster care, care for the spouse, child or parent of the employee if the individual has a serious health condition or because of a serious health condition, the employee is unable to perform any one of the essential functions of the employee's regular position. In addition, FMLA requires an employer to allow eligible employees to take up to 12 weeks of leave per 12-month period for qualifying exigencies arising out of a covered family member's active military duty in support of a contingency operation and to take up to 26 weeks of leave during a single 12-month period to care for a covered family member recovering from a serious illness or injury incurred in the line of duty during active service.

Any employee taking a leave under the FMLA shall be entitled to continue the employee's benefits during the duration of

the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. **Please note:** The employee is still responsible for paying their share of the premium if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the FMLA does not constitute a qualifying event so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of the approved period of Family and Medical Leave and terminates employment with employer, the COBRA qualifying event occurs at that time.

If you have any questions regarding your eligibility or obligations under the FMLA, contact your employer or group sponsor.



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# 10. Claims

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Once you receive medical services or purchase prescription drugs from a nonparticipating pharmacy we must receive a claim to determine the amount of your benefits. The claim lets us know the services or prescription drugs 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.
- Purchase prescription drugs from a nonparticipating pharmacy.
- Purchase prescription drugs from a participating pharmacy but do not present your ID card.
- Pay in full for a drug that you believe should have been covered.

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

Wellmark must receive claims within 365 days following the date of service of the claim.

## How to File a Claim

All claims must be submitted in writing.

### 1. Get a Claim Form

Forms are available at [www.wellmark.com](http://www.wellmark.com) or by calling the Customer Service number on your ID card or from your personnel department.

### 2. Fill Out the Claim Form

Follow the same claim filing procedure regardless of where you received services. Directions are printed on the back of the

claim form. Complete all sections of the claim form. For more efficient processing, all claims (including those completed out-of-country) should be written in English.

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

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

- Use a separate claim form for each covered family member and each provider.
- Attach a copy of an itemized statement prepared by your provider. We cannot accept statements you prepare, cash register receipts, receipt of payment notices, or balance due notices. In order for a claim request to qualify for processing, the itemized statement must be on the provider's stationery, and include at least the following:
  - Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
  - Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.
  - Date(s) of service.
  - Charge for each service.
  - Place of service (office, hospital, etc).
  - For injury or illness: date and diagnosis.
  - For inpatient claims: admission date, patient status, attending physician ID.
  - Days or units of service.
  - Revenue, diagnosis, and procedure codes.
  - Description of each service.

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

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

**Prescription Drug Claim Form.** For prescription drugs covered under the prescription drug plan prescription drug plan, complete the following steps:

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

### 3. Sign the Claim Form

#### 4. Submit the Claim

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

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

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

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

BlueCard Worldwide Service Center  
P.O. Box 72017  
Richmond, VA 23255-2017

**Claims for Drugs Covered Under the Prescription Drug Plan.** Send the claim to:

Catalyst Rx  
Claims Department  
P.O. Box 1069  
Rockville, MD 20849-1069

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

### Notification of Decision

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

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

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

If you have other insurance coverage, our processing of your claim may utilize coordination of benefits guidelines. See *Coordination of Benefits*, page 77.

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



# 11. Coordination of Benefits

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

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

## Other Coverage

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

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

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

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.

- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for non-medical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

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

Your participating or PPO provider will forward your coverage information to us. If you have a nonparticipating provider, you are responsible for informing us about your other coverage.

## Claim Filing

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

## Rules of Coordination

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

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide out-of-network benefits.)
- The coverage that you have as an employee, plan member, subscriber, policyholder, or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a

result, the plans do not agree on the order of benefits, this rule is ignored.

- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Notwithstanding the preceding rules, when you use your prescription drug plan ID card, the benefits of the prescription drug plan prescription drug plan are primary for prescription drugs purchased at a pharmacy.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

### **Dependent Children**

To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- If the child is covered by both parents who are married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:

- If a court decree states that one of the parents is responsible for the child’s health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent’s coverage pays first. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
- If a court decree states that both parents are responsible for the child’s health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

If none of these rules apply to your situation, we will follow the Iowa Insurance

Division’s Coordination of Benefits guidelines to determine this health plan payment.

**Effects on the Benefits of this Plan**

When this plan is secondary, we may reduce its benefits so that total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

**Right of Recovery**

If the amount of payments made by us is more than we should have paid under these coordination of benefits provisions, we may recover the excess from any of the persons to or for whom we paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

**Coordination with Medicare**

For medical claims only, Medicare is by law the secondary coverage to group health plans in a variety of situations. **Please note:** For a member covered by Medicare Part A, benefits under this medical benefits plan will be coordinated with benefits available under Medicare Part A and Part B, even if the member is not enrolled in Medicare Part B. Therefore, a member enrolled in Medicare Part A should also consider enrolling in Medicare Part B.

The following provisions apply only if you have both Medicare and employer group health coverage under this medical benefits plan and your employer has the required minimum number of employees.

**Working Aged**

If you are a member of a group health plan of an employer with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year, then Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current employee or spouse of a current employee covered by an employer group health plan.

**Working Disabled**

If you are a member of a group health plan of an employer with at least 100 full-time, part-time, or leased employees on at least 50 percent of regular business days during the preceding calendar year, then Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by an employer group health plan.

**End-Stage Renal Disease (ESRD)**

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these requirements, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- The beneficiary has Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the

secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary becomes covered for ESRD, the group health plan remains secondary to Medicare.

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

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# 12. Appeals

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## Right of Appeal

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

- Continued stay in a facility.
- A precertification request.
- A prior approval request.
- A prior authorization request for prescription drugs.

## How to Appeal

You or your authorized representative, if you have designated one, may appeal a reduced or denied benefit by calling the Customer Service number on your ID card or by writing to Wellmark. See *Authorized Representative*, page 85.

### Medically Urgent Appeal

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

### Non-Medically Urgent Appeal

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

### What to Include in Your Appeal

You must submit all relevant information with your initial appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.

- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

**For a prescription drug appeal**, you also must submit:

- Name and phone number of the pharmacy.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

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

## Where to Send Appeal

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

## Review of Appeal

Your request for an appeal will be reviewed only once. The review will take into account all information regarding the adverse decision whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial decision.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, we will consult an appropriate medical expert who was not previously involved in the original decision. If we deny your appeal, in whole or

in part, you may request, in writing, the identity of the medical expert we consulted.

### **Decision on Appeal**

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

### **Medically Urgent Appeal**

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

### **Non-Medically Urgent Appeal**

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

### **Legal Action**

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

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# 13. Your Rights Under ERISA

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## **Employee Retirement Income Security Act of 1974**

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

As a participant in this group health plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

## **Receive Information About Your Plan and Benefits**

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

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

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

## **Continued Group Health Plan Coverage**

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. However, you or your dependents may have to pay for such coverage. For more information on the rules governing your COBRA continuation coverage rights, review this summary plan description and the documents governing the plan. See *COBRA Continuation*, page 63.

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

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

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

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion period for up to 12 months (up to 18 months for late enrollees) after your enrollment date in the coverage. See *Certificate of Creditable Coverage*, page 63.

## **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of your employee benefits plan. The people who operate the plan, called *fiduciaries* of the plan, have a duty to do so prudently and in the interest of you and other plan

participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforcement of Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance With Your Questions**

If you have any questions about your plan, you should contact the plan administrator. If you have questions about this statement

or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor*, listed in the telephone directory, or write to:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the *Employee Benefits Security Administration*.

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# 14. General Provisions

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## Contract

The conditions of your coverage are defined in your contract. Your contract includes:

- Any application you submitted to us or to your plan sponsor.
- Any agreement or group policy we have with your plan sponsor.
- Any application completed by your plan sponsor.
- This summary plan description and any riders or amendments.

All of the statements made by you or your plan sponsor in any of these materials will be treated by us as representations, not warranties.

## Interpreting this Summary Plan Description

We will interpret the provisions of this summary plan description and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this summary plan description. If any benefit described in this summary plan description is subject to a determination of medical necessity, we will make that factual determination. Our interpretations and determinations are final and conclusive.

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

## Authority to Terminate, Amend, or Modify

Your plan sponsor has the authority to terminate, amend, or modify the coverage described in this summary plan description

at any time. Any amendment or modification will be in writing and will be as binding as this summary plan description. If your contract is terminated, you may not receive benefits.

## Authorized Group Health Plan Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions described in this summary plan description. This summary plan description cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your plan sponsor.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 59.

## Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at [www.wellmark.com](http://www.wellmark.com) or by calling the Customer Service number on your ID card.

In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form.

An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You may authorize only one person as your

representative at a time. You may revoke the authorized representative at any time.

## **Release of Information**

You have agreed in your application (or in documents kept by us or your plan sponsor) to release any necessary information requested about you so we can process claims for benefits.

You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application, then we may terminate your coverage under this group health plan.

## **Privacy of Information**

Your plan sponsor is required to protect the privacy of your health information. It is required to request, use, or disclose your health information only as permitted or required by law. For example, your plan sponsor has contracted with Wellmark to administer this group health plan and Wellmark will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

### **Treatment**

We may disclose your health information to a physician or other health care provider in order for such health care provider to provide treatment to you.

### **Payment**

We may use and disclose your health information to pay for covered services from physicians, hospitals, and other providers, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain payment from your plan sponsor, to issue explanations of benefits to the person enrolled in the group health plan in which you participate, and the like. We

may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

### **Health Care Operations**

We may use and disclose your health information in connection with health care operations. Health care operations include, but are not limited to, determining payment and rates for your group health plan; quality assessment and improvement activities; reviewing the competence or qualifications of health care practitioners, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities; medical review, legal services, and auditing, including fraud and abuse detection and compliance; business planning and development; and business management and general administrative activities.

### **Other Disclosures**

Your plan sponsor or Wellmark is required to obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, we may release claim payment information to a friend or family member to act on your behalf during a hospitalization if you submit an authorization to release information to that person.

## **Member Health Support Services**

Wellmark may from time to time make available to you certain health support services (such as disease management), for a fee or for no fee. Wellmark may offer financial and other incentives to you to use such services. As a part of the provision of these services, Wellmark may:

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health

support service vendors, for purposes of providing such services to you.

Wellmark will use and disclose information according to the terms of our Privacy Practices Notice, which is available upon request or at [www.wellmark.com](http://www.wellmark.com).

### **Value Added or Innovative Benefits**

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions.

### **Health Insurance Portability and Accountability Act of 1996**

#### **Group Sponsor's Certification of Compliance**

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

#### **Purpose of Disclosure to Group Sponsor**

Your group health plan, any business associate servicing your group health plan, or Wellmark will disclose protected health information to your group sponsor only to permit the group sponsor to perform plan administration of the group health plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its

implementing regulations (45 C.F.R. Parts 160-64). Any disclosure to and use by your group sponsor of protected health information will be subject to and consistent with the provisions identified under *Restrictions on Group Sponsor's Use and Disclosure of Protected Health Information and Adequate Separation Between the Group Sponsor and the Group Health Plan*, later in this section.

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

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

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

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

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

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

Your group sponsor will report to the group health plan, any use or disclosure of protected health information that is

inconsistent with the uses and disclosures stated in this provision promptly upon learning of such inconsistent use or disclosure.

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

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

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

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

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

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

integrity, and availability of electronic protected health information.

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

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

### **Adequate Separation Between the Group Sponsor and the Group Health Plan**

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

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

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

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

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

### **Nonassignment**

Benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. You are prohibited from assigning any claim or cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan or rights to payment will be void.

### **Governing Law**

To the extent not superseded by the laws of the United States, the group health plan will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this plan will be litigated in the state or federal courts located in the state of Iowa and in no other.

### **Legal Action**

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

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

which the services or supplies were provided.

## **Medicaid Enrollment**

### **Assignment of Rights**

This group health plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

### **Enrollment Without Regard to Medicaid**

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of any benefits paid to you.

### **Acquisition by States of Rights of Third Parties**

If payment has been made by Medicaid and Wellmark has a legal obligation to provide benefits for those services, Wellmark will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

## **Subrogation**

### **Right of Subrogation**

If you or your legal representative have a claim to recover money from a third party and this claim relates to an illness or injury for which this group health plan provides benefits, we, on behalf of your plan sponsor, will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

### **Right of Reimbursement**

If you are injured as a result of the act of a third party and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse us for all benefits paid for

the injury from money received from the third party or its insurer, to the extent of the amount paid by this group health plan on the claim.

Once you receive benefits under this group health plan arising from an illness or injury, we will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any of the following:

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

You agree to recognize our rights under this group health plan to subrogation and reimbursement. These rights provide us with a priority over any money paid by a third party to you relative to the amount paid by this group health plan, including priority over any claim for non-medical charges, or other costs and expenses. We will assume all rights of recovery, to the extent of payment made under this group health plan, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

### **Procedures for Subrogation and Reimbursement**

You or your legal representative must do whatever we request with respect to the exercise of our subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform us in writing if you were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such injury to us as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by us.

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa  
636 Grand Avenue, Station 151  
Des Moines, IA 50309-2565

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.

- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid under this group health plan in connection with the illness or injury) in trust for the benefit of this group health plan as trustee(s) for us until the extent of our right to reimbursement or subrogation has been resolved.
- The amount of our subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses, and the “make whole” rule is specifically rejected and inapplicable under this group health plan.
- We will not be liable for payment of any share of attorneys’ fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing, and the “common fund” rule is specifically rejected and inapplicable under this group health plan.

It is further agreed that in the event that you fail to take the necessary legal action to recover from the responsible party, we shall have the option to do so and may proceed in its name or your name against the responsible party and shall be entitled to the recovery of the amount of benefits paid under this group health plan and shall be

entitled to recover its expenses, including reasonable attorney fees and costs, incurred for such recovery.

In the event we deem it necessary to institute legal action against you if you fail to repay us as required in this group health plan, you shall be liable for the amount of such payments made by us as well as all of our costs of collection, including reasonable attorney fees and costs.

You hereby authorize the deduction of any excess benefit received or benefits that should not have been paid, from any present or future compensation payments.

You and your covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

Our right of subrogation and reimbursement under this group health plan applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and reimbursement if there is any recovery on your claim.

We reserve the right to offset any amounts owed to us against any future claim payments.

### **Workers’ Compensation**

If you have received benefits under this benefits plan for an injury or condition that is the subject or basis of a workers’ compensation claim (whether litigated or not), we are entitled to reimbursement to the extent of benefits paid under this plan from your employer, your employer’s workers’ compensation carrier, or you in the event that your claim is accepted or adjudged to be covered under workers’ compensation.

Furthermore, we are entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. We will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

We utilize industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. We reserve the right to seek reimbursement of any such claim or to waive reimbursement of any claim, at our discretion.

### **Payment in Error**

If for any reason we make payment in error, we may recover the amount we paid.

### **Notice**

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

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

Any notice from Wellmark to you is acceptable when sent to your address as it appears on Wellmark's records or the address of the group through which you are enrolled.

# Glossary

The definitions in this section are terms that are used in various sections of this summary plan description. A term that appears in only one section is defined in that section.

**Accidental Injury.** An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

**Admission.** Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

**Amount Charged.** The amount that a provider bills for a service or supply or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

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

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

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

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

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).

- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.

**Group.** Those plan members who share a common relationship, such as employment or membership.

**Group Sponsor.** The entity that sponsors this group health plan.

**Illness or Injury.** Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

**Inpatient.** Services received, or a person receiving services, while admitted to a health care facility for at least an overnight stay.

**Medical Appliance.** A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood

pressure); or to administer drugs (such as syringes).

**Medically Urgent Situation.** A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed without the services in question.

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

**Member.** A person covered under this group health plan.

**Nonparticipating Pharmacy.** A pharmacy that does not participate with the network used by this prescription drug benefits plan.

**Nonparticipating Provider.** A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan.

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

**Participating Pharmacy.** A pharmacy that participates with the network used by this prescription drug benefits plan.

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

**Plan.** The group health benefits program offered to you as an eligible employee for purposes of ERISA.

**Plan Administrator.** The plan sponsor of this group health plan for purposes of the Employee Retirement Income Security Act.

**Plan Member.** The person who signed for this group health plan.

**Plan Sponsor.** The entity that sponsors this group health plan.

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

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

**Specialty Drugs.** Drugs that are typically used for treating or managing chronic illnesses. These drugs often require special handling (e.g., refrigeration) and administration. Some specialty drugs may be taken orally, but others may require administration by injection, infusion, or inhalation. Specialty drugs may not be available from a retail pharmacy.

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

**We, Our, Us.** Wellmark Blue Cross and Blue Shield of Iowa.

**X-ray and Lab Services.** Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

**You, Your.** The plan member and family members eligible for coverage under this group health plan.

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